

An Independent Investigation into the conduct of the '4-Nations IPC Cell'

A report for consideration by the
UK COVID-19 Inquiry Team and Core Participants



5 March 2026
(Redacted version)

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Executive Summary

In its opening submission to the Inquiry, CATA pledged to help the Inquiry conduct an effective investigation and assist in uncovering evidence which would enable the Chair to make informed recommendations which would improve the nation's resilience to future pandemics.

In its closing submission we stressed the need for the Inquiry to collate evidence which may determine whether there has been a 'culpable state failure to preserve life' during the pandemic¹. We also respectfully reminded the Inquiry that, even though it has no power to determine civil or criminal liabilities, it should not be inhibited from determining the facts or making recommendations². This is something that CATA urges the Inquiry to do, for the sake of the countless frontline healthcare workers who have lost their lives or been left with debilitating health conditions. The litigants in the impending class action depend on it and have a right to it.

Apart from its written and oral submissions, the CATA Executive Team has conducted extensive investigations of its own. This has taken hundreds of hours of work over five years. This report sets out evidence – in summary:

- state bodies appear to have withheld relevant and important documents from the Inquiry;
- amendments were made to the minutes of IPC Cell meetings (December 2020), changing 'consensus':
 - **from** 'precautionary approach' as advocated by Public Health England (i.e. wider use of FFP3 respirators)
 - **to** 'no change to the PPE recommendations in the IPC Guidance';
- an HSE official's email to the IPC Cell was deliberately falsified, distorting the intended meaning so as to convey a message supportive of the Cell's position, then publicly displayed by ARHAI Scotland;
- calling the competence of IPC Cell members into question regarding basic health and safety principles;
- critical of the DHSC handling of a meeting with representatives of over a million healthcare workers:
 - imposing the 'Chatham House' rule without prior discussion with stakeholders, evidencing the lack of openness and transparency which pervaded the Government's handling of the emergency;
 - denying PHE experts the opportunity to participate in the meeting once it was realised that they supported the stakeholders' position for extending use of FFP3;
 - Concealing key evidence from stakeholders concerning airborne transmission; failing to engage with them to agree the way forward based on the scientific evidence for airborne transmission and risk management;
- authors of ARHAI 'Rapid reviews of Literature' (highly influential on IPC guidance) repeatedly misunderstanding and misrepresenting scientific/research papers, thereby conveying misinformation (arguably disinformation) on the relative efficacy of surgical masks vs respirators;
- some members of IPC Cell were more concerned about reputational risks to themselves, losing their independence and concerned that PHE might override their fixed views on transmission and PPE;
- The Health and Safety Executive turned its back on the healthcare sector, abrogating its statutory duties to ensure that employers protected the safety of their employees. Instead of enforcing statutory health and safety provisions it enforced compliance with IPC guidance which it knew, or should have known, exposed healthcare workers to mortal danger by inhalation of aerosolised SARS-CoV-2 virions;
- Our findings expose multiple failings across Government; a lack of effective governance over IPC and health & safety arrangements and weak leadership;
- Key decisions were made on the basis of dubious computer modelling and 'rapid literature reviews' rather than extant knowledge and straightforward common sense. Experts were appointed who lacked expertise.
- We find the most unforgivable aspect of the pandemic has been how the personal views, opinions and objectives of a relatively small number of individuals in senior positions of authority ignored the chorus of concern from stakeholder organisations about the inadequacy of the PPE requirements of IPC guidance which was plain to see;
- The attempts by state bodies to frustrate our investigations via Freedom of Information requests, together with the evidence produced by those requests strongly suggest an orchestrated cover-up on an astronomical scale;

Prima-facie evidence is presented in this report of offences having been committed under criminal law, public law (the Inquiries Act) and civil law, the tort being a gross failure in organisations' duty of care to workers whose health and safety they knew would be affected by the IPC guidance they published. This is for others to pursue.

¹ Article 2 of the European Convention on Human Rights

² Section 2(2) of the Inquiries Act 2005

Foreword

This is the fourth report in a series prepared by members of the Covid Airborne Transmission Alliance (CATA) and its precursor organisation, the AGP Alliance (AGP-A) in respect of the COVID-19 pandemic:

- 1) In June 2021 two reports were submitted to the Commons Public Accounts and Health & Social Care Select Committees.^{3 4}.

These reports formally put Government on notice that its frontline health and social care workers were being placed in mortal danger by the provision of woefully inadequate respiratory protection which endangered their lives. The essence of these reports can best be summed up in one paragraph taken from the report to the H&SC Committee : ***“It was wrong to mislead HCWs that surgical masks adequately protect them. An analogy might be drawn between sending HCWs to fight a war against a virus on the one hand vs soldiers being sent to fight a battle with rifles loaded with blank ammunition”.***

As a portent of things to come, neither committee took any notice of these warnings. The reports were consigned to a one-line entry in “documents submitted” at the end of the Committees’ final reports ^{5 6}. The reports also put the Government on notice that offences were being committed under health and safety legislation, specifically regulation 7(9) of the COSHH Regulations ^{7 †}, but no heed was paid to this.

- 2) The third report was entitled “Changes in the Management of COVID-19 : 13th March 2020”. This was submitted to the UK COVID-19 Inquiry in July 2024. That report involved sifting through 17,000 documents disclosed by the Inquiry to Module 3 Core Participants (CPs).

Key events were identified which led up to the issue of the 4-Nations Infection Prevention and Control (IPC) guidance on 13 March 2020 and the CAS alert which downgraded respiratory protection for healthcare workers (HCWs) from effective HSE-approved respirators such as filtering facepieces (FFP3) to Fluid Resistant Surgical Masks (FRSM) which are neither HSE-approved nor effective against airborne, inhalable pathogens. FRSMs are not Personal Protective Equipment (PPE) under UK legislation. They provide little, if any, protection against COVID-19 or other airborne diseases such as flu, RSV, TB etc. More technical and legal information about this can be found at sections 5 and 6 in the H&SC report ².

The report also analysed the evidence surrounding the declassification of COVID-19 as a High Consequence Infectious Disease and explained why this happened at the same time as the downgrade in PPE. This is a topic which has caused much speculation and some misunderstanding.

The report was written in order to assist the Inquiry (meaning the Inquiry’s legal team and also other CPs) in their understanding of what went on at this pivotal moment in the pandemic which has affected (and cost) so many lives. The intention was to provide the information to all parties in good time before the Module 3 public hearings began in the autumn of 2024. It was anticipated that the Inquiry would honour the commitment stated in section 2(1) of its ‘Core Participant protocol’ ⁸ and distribute copies of the report to CPs via its ‘RELATIVITY’ document management system. However, for reasons which have never been explained, the Inquiry did not disclose the report to CPs before the public hearings and has not done so since.

- [†] COSHH was not the only legislation applicable to those circumstances. At a different legislative level, the actions of Government sending HCWs into danger at the COVID ‘front line’ while misleading them about respiratory protection, represents a potential breach of the State’s duty under Article 2 of the European Convention on Human Rights (ECHR) aka ‘Right to Life’.

³ Written Evidence submitted to the Public Accounts Select Committee – June 2021 - [Link](#)

⁴ Written Evidence submitted to the Health & Social Care Select Committee – June 2021 – [Link](#)

⁵ House of Commons, Public Accounts Select Committee: Initial lessons learned from the Government response to the pandemic: July 2021 [Link](#)

⁶ House of Commons, Health and Social Care & Science and Technology Committees : Coronavirus: Lessons Learned to Date: [Link](#)

⁷ COSHH : Control of Substances Hazardous to Health Regulations 2002 (as amended)

⁸ UK COVID-19 Inquiry ‘Core Participant Protocol’ ([Link](#)) : s2(a): ***“CPs will be provided with electronic disclosure of evidence relevant to the particular subject matter of the Inquiry in respect of which they are so designated...”***

As will become clear in this report, State bodies appear to have withheld certain key documents from the Inquiry which, under their ‘rule 9’ requirements, they should have submitted. The Inquiry is invited to investigate this further since (a) it represents a potential offence by State organisations or individuals under section 35(3)(a) of The Inquiries Act 2005, and (b) the Inquiry’s findings, conclusions and recommendations in its Module 3 report will be incomplete and may therefore be flawed if it has not been able to consider important and relevant evidence which has been concealed from it by State bodies.

This finding is based on the fact that relevant documents have been disclosed to CATA by State bodies in response to Freedom of Information (Fol) requests (*often only when forced to do so by the Information Commissioner’s Office {ICO}*), but which cannot be found amongst the 17,000 documents disclosed to Module 3 CPs.

The Inquiry may therefore wish to consider the additional evidence provided in this report in its Module 3 investigation since these documents are extremely relevant to Module 3. This may involve the Inquiry in requesting unredacted versions of the documents from the public authorities concerned.

Although this report primarily concerns the acts and omissions of the group known as the ‘4-Nations IPC Cell’, this inevitably leads to some consideration of the key organisations with whom they interacted, most notably:

- Antimicrobial Resistance and Healthcare Associated Infection Scotland (**ARHAI**), a Department of NHS National Services Scotland;
- the Health and Safety Executive (**HSE**);
- Public Health England (**PHE**) and its successor the UK Health Security Agency (**UKHSA**); and
- The Department of Health and Social Care (**DHSC**).

This report does not have a “conclusions” section. Its purpose is to provide such documentary evidence, together with any associated explanation or context as may be necessary to enable the reader to form their own conclusions.

This report should be seen entirely in that light and, although it raises possible questions about the conduct of certain individuals, it is not setting out any accusations or allegations against any individual or organisation – just providing the evidence and context – no more than that. It will be up to the Inquiry and other readers to decide for themselves whether the acts or omissions of these individuals represent culpable or discreditable conduct.

1. Introduction, background, scope and conventions used in this report

1.1. Research methodology, limitations and assumptions

Much of the information included in this report has been obtained via Freedom of Information (Fol) requests, together with documents which have been disclosed by the UK COVID-19 Inquiry. In both cases the authorities have redacted personal data, most notably people's names sending or receiving emails.

Documents disclosed by the Inquiry are based on its own '[redaction protocol](#)' and do not redact the names of individuals whose "***involvement in events is relevant***" or "***because it is necessary in order to allow people to properly follow the narrative of events***".

By comparing these two sets of documents, together with (a) individuals' witness statements (made with a signed affirmation of truth), and (b) oral evidence given under oath at the Inquiry, it is possible to **suggest** tentatively the identities of some individuals to whom redactions in Fol documents **may** refer. A protocol is used in this report to help readers follow the narrative of events with a reasonable degree of confidence (i.e. mirroring the Inquiry's stated intention above). In order to distinguish such "tentative" identities from actual known identities, a convention will be adopted of formatting names and initials using red font in italics in square brackets thus [**Name**]. It must be emphasized that these are in no way definitive attributions of identity but are offered on the basis that reasonable evidence or context exists which supports the attribution, therefore no-one should draw any firm conclusions from such identity attributions. Names will only be shown in this way if the individuals involved are left unredacted by the Inquiry in documents that they disclose. Where names are known but it appears that the individual is relatively junior and not a "decision maker" then the name will not be shown (again, following Inquiry's redaction protocol and that of the Department of Health and Social Care (DHSC)).

Full titles (including Sir, Dame etc) for individuals are not used on each and every occurrence. Honours (CBE, OBE etc) are not stated. No disrespect is intended to these individuals.

1.2. Brief explanation of the functions and terms of reference of the 4-Nations IPC Cell

The IPC Cell was a committee, initially established by NHS-E/I's 'National Incident Response Board' towards the end of January 2020. It comprised members from the four UK nations:

- NHS England/Improvement (NHS-E/I) (*hereafter just referred to as NHS-E*)
- Public Health England (PHE)
- Public Health Wales (PHW)
- Antimicrobial Resistance and Healthcare Associated Infection, Scotland (ARHAI)
- The Scottish Government Healthcare Associated Infection (HCAI) Policy Unit
- The Public Health Agency of Northern Ireland (PHA)
- The Association Ambulance of Chief Executives (AACE)

Administration/Secretariat functions were provided by NHS England, including the taking of minutes.

Meetings were initially chaired either by Ms Linda Dempster or Ms Gaynor Evans (both NHS-E).

Dr Lisa Ritchie (NHS-E) took over as Chair on 27 May 2020 through until the end of March 2021 when Dr Eleri Davies (PHW) took over and continued until the end of March 2022, when the Cell was stood down.

Although representatives from Scotland and Northern Ireland never took the role of Chair, their key members appear to have been Ms Laura Imrie from ARHAI, Scotland and Mr Rodney Morton (Chair of the Northern Ireland IPC Cell).

Mr David Cunningham represented the AACE for the ambulance service.

During the lifetime of the Cell there were approximately 120 meetings.

Members representing the three devolved administrations reported back to their respective Governments – usually the Chief Nursing Officers (CNOs) and Chief Medical Officers (CMOs) and Public Health bodies. However, these organisations/individuals never made any material changes to the IPC guidance documents produced by the Cell.

In England, the CNO (Dame Ruth May) was the Senior Responsible Officer for the Cell, with her Deputy CNO (DCNO) directly overseeing the work of the Cell. This was Ms Sumeshni (Sue) Tranka until the end of August 2021, followed by

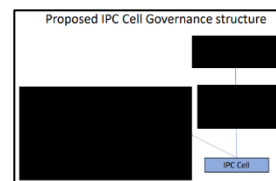
Mr Duncan Burton. Another influential figure in NHS England's IPC structure was Professor Mark Wilcox (National Clinical Director for IPC) who attended several Cell meetings and was a close adviser to the CNO, DCNO and Cell Chair. Public Health England published the IPC Cell guidance on the gov.uk website. As a result, there was a common misperception that PHE was responsible for producing the IPC guidance and all of its contents (particularly the PPE requirements). This was not the case.

A number of PHE IPC experts were members of the Cell and provided technical and scientific input to the Cell. Under UK emergency planning arrangements, PHE was the designated UK lead Department in response to pandemic emergencies. The PHE representatives at the Cell made numerous recommendations (particularly in relation to PPE) which were not well received by others in the Cell, nor were they ever implemented.

Indeed, Cell minutes reveal indications of a certain resentment by ARHAI in relation to the input from PHE. For instance, at a meeting in May 2021 concerns were aired by an ARHAI representative in relation to the Cell "losing its independence" and being "driven" by PHE.⁹ However, the evidence suggests that this perception was ill-founded, with PHE playing a responsible, helpful and professional role at all times. Such tensions between the parties were not only inappropriate and unhelpful during a global pandemic, but also very dangerous when the Cell's primary considerations should have been 100% focused on the more important matters of life and death for healthcare workers (literally).

Unlike other Government organisations and committees (such as SAGE, NERVTAG, ACDP etc) the minutes of IPC Cell meetings were never published and few details were available concerning its membership. The Cell therefore gained the reputation of being a secretive, shadowy group whose decisions were directly impacting on the health and safety of over a million healthcare workers and, in the perception of many, were costing healthcare worker lives due to its recommendations for inadequate personal protection against the virus.

Even now, despite the fact that the Cell was stood down over 3½ years ago, no minutes or 'terms of reference' for the Cell have yet been (voluntarily) published. A few sets of minutes have been extracted from the authorities but not without a hard-fought struggle, often needing to involve the Information Commissioner's Office to force disclosure of the documents. The process can best be described as like 'pulling teeth' with the authorities trying every trick in the book to avoid disclosing relevant material (aka 'cover-up'). One such example is shown here:



The Cell's Terms of Reference were exhibited by Dr Lisa Ritchie along with her witness statement.¹⁰ The Inquiry has not released these into the public domain so they cannot be fully disclosed here, though Core Participants in Module 3 may access the disclosed documents via the references below.¹¹ However, a colleague eventually extracted the Terms of Reference for the Cell as at 18 Aug 2020.¹²

Some insight into the membership of the Cell can be seen in documents published by the UK Covid-19 Inquiry such as [INQ000348370](#). It should be stressed that the acts and omissions of the few individuals that are scrutinised within this report should not adversely reflect upon Cell members as a whole. It is recognised that those were extraordinary times and many individuals found themselves in positions which they could never ever have envisaged before the pandemic struck. There is no doubt that many people (within the Cell and without) worked incredibly hard under very stressful circumstances.

⁹ INQ000398232 [p.1-3] : Extract from minutes of the IPC Cell meeting (12 May 2021) ([Link](#))

¹⁰ Witness statement of Lisa Ritchie : INQ000421939 : Paragraph 140 (Terms of Reference for IPC Cell) – [Link](#)

¹¹ IPC Cell Terms of Reference - Inquiry INQ N°s: 3/3/20=489995, 13/6/20=489996, 18/8/20=348137, 18/8/21=489988, 15/9/21=413483

¹² Terms of Reference for the IPC Cell : 18 August 2020 – [Link](#)

1.3. Recap on events leading up to 13 March 2020

The report ‘Changes in the Management of COVID-19, mid March 2020’ covered the development of IPC guidance up to and including the issue of version 1.0 of the 4-Nations IPC Guidance which downgraded protections for most healthcare workers (HCW) from effective Respiratory Protective Equipment (RPE) such as FFP3 respirators to Fluid Resistant Surgical Masks (FRSM), leaving them unprotected and defenceless against a lethal pandemic airborne disease which was fast spreading through the community. Professor Chris Whitty, in his oral evidence to the Inquiry did not accept that the change from FFP3 to FRSM should be categorised as “downgrading” but a normal move from a High Consequence Infectious Disease (HCID). The Inquiry’s expert IPC witnesses disagreed, stating that the two issues of HCID status and the mode of transmission/PPE were completely separate and it is entirely possible to declassify a disease as an HCID whilst still retaining the need for enhanced PPE such as FFP3 if the disease presents a hazard to health via the inhalation route (which COVID-19 does).¹³

The draft of that IPC guidance document was prepared by Dr Lisa Ritchie and Professor Sir Jonathan Van Tam (hereafter referred to as JVT), who forwarded it to Professor Keith Willett (Strategic Incident Director, NHS England) and Professor Susan Hopkins (COVID-19 Incident Director, Public Health England) on 12 March 2020. Shortly afterwards, Professor Sir Chris Whitty (Chief Medical Officer {England}) issued a communication via the ‘Central Alerting System’ (CAS) which denied most healthcare workers the protection afforded by FFP3 respirators. FRSMs were to be used instead. For a person in his position he knew, or should have known, that these would not provide adequate protection against a virus classified as airborne. This is one of the most basic, fundamental principles of occupational health and safety. For more information and a definitive explanation of the legal position (supported by HSE’s Chief Scientific Advisor), see the guidance published by the British Occupational Hygiene Society.¹⁴

The following morning, during a NERVTAG meeting, it was realised that the downgrade to FRSM had taken place whilst the disease was still classified as a High Consequence Infectious Disease, for which the health and safety rules stated that FFP3 respirators must be worn. JVT therefore contacted the Chair of the committee (ACDP ¹⁵) which determines what is (and what isn’t) an HCID. The disease was conveniently declassified as an HCID a few minutes later.

The basis for the IPC Cell’s PPE downgrade centred on their assertion that the disease was only transmitted (a) by contact with contaminated surfaces (otherwise known as ‘fomites’) and subsequent transfer by hand to mouth/nose/eyes; and (b) by ballistic droplets which fell to ground within 1 – 2 metres but (they repeatedly maintained) **not** by the airborne route. No credible evidence was presented for the “droplet” route as opposed to the “aerosol/airborne” route and none has been produced since, yet the Government still clings to that now discredited dogma.

1.4. Scope of this report

This report continues on from March 2020 as evidence for airborne transmission mounted, exposing the deep-seated flaws embedded within the IPC guidance. It is not within the scope of this report to reproduce, discuss or debate the actual evidence for airborne transmission. This report focuses more on the questionable behaviours[†] of certain members of the IPC Cell and other healthcare leaders including Chief Medical Officers, Chief Nursing Officers, the Secretary of State for Health and Social Care, Directors of IPC etc once that evidence was put to them.

[†]e.g., concern that changing PPE guidance would infer ‘having got it wrong’; personal reputations at stake; political influence being brought to bear (as discussed in the foreword above).

¹³ Expert report by Dr Gee Yen Shin, Prof Dinah Gould and Dr Ben Warne : Infection Prevention and Control – the challenges : paragraph 6.9 ([Link](#))

¹⁴ British Occupational Hygiene Society: Guidance for Employers on the use of FRSMs and FFP3s to comply with COSHH Regulations ([Link](#))

¹⁵ ACDP = The Advisory Committee on Dangerous Pathogens, Chaired at the time by Professor Tom Evans.

Neither does this report cover the frequent challenges to the IPC Guidance made by external bodies such as the AGP Alliance (later CAPA/CATA), BMA, RCN, TUC etc, except on the one occasion when all these organisations came together as the ‘stakeholder side’ at a crucial meeting with the ‘Government side’ (IPC Cell, DHSC, CNOs etc) on 3 June 2021 where, as will be explained in section 4, the acts and omissions of the Government side were shameful.

The decision to downgrade RPE to FRSM made in March 2020 was at a time when there was a world shortage of FFP3 and other Respiratory Protective Equipment (RPE). Even when the shortages of RPE had passed and stocks had been replenished, the IPC Cell (and others) resolutely clung to the dogma that airborne transmission of COVID-19 is insignificant and FRSM will keep healthcare workers safe.

This report describes a succession of challenges to the IPC Cell’s guidance by senior officials within State bodies such as Chief Nursing Officers and highly competent, ethically-principled individuals such as Dr Colin Brown (PHE/UKHSA) and Ms Miranda Morton (Welsh Government’s Directorate for Health Policy, Technical Advisory Cell).

1.5. Conventions used in this report

1.5.1. Conventions relating to confidentiality

This report contains information taken from confidential documents disclosed by the UK COVID-19 Inquiry to Module 3 Core Participants (CPs) who are subject to strict ‘confidentiality undertakings’. These undertakings are legally enforceable.

However, much of the information contained in this report has been obtained by independent research, mostly via Freedom of Information requests and is not, therefore, subject to Confidentiality Undertakings.

It is expected that the topics covered in this report will be of interest beyond the confines of the Inquiry and its core participants and it has been written in that light. It may be of interest to the thousands of healthcare workers whose health and wellbeing have been so badly impacted by their occupational exposure to COVID-19 during the pandemic and the bereaved families of those who paid the ultimate price. It is also likely to be of interest to the thousands of bereaved families who lost loved ones through healthcare-acquired infections, either as patients in hospitals or as residents in care homes and similar settings.

Above all, it is considered that publication of this report is justified in the more general interests of openness and transparency (*features which were in remarkably short supply during the lifetime of the IPC Cell and which have remained so ever since*).

However, CATA members are constrained by their own confidentiality undertakings to the Inquiry Chair, Baroness Hallett, and take this very seriously. It has therefore been necessary to redact certain swathes of text where this would otherwise breach confidentiality rules. This has been implemented via the “_” (underscore) rather than the traditional “■” as this is considered more ‘user-friendly’ for those who wish to print the report as a hardcopy.

Where confidential documents are referenced in the footnotes, a convention has been followed by citing the Inquiry’s reference number (the ‘INQ’ number) being indicated thus: “¹ INQ000nnnnnn”, with the description of the contents having been removed. Anyone wishing to have sight of any of these documents will need to apply to the Inquiry Chair and request disclosure. Similarly, anyone wishing to have sight of this whole, unredacted document, will need to apply to the Inquiry Chair and request disclosure.

1.5.2. Conventions relating to internet links used in this report to defeat Government ‘airbrushing’

Readers intending to visit the web links in the footnotes to view the supporting evidence need to read this.

Links provided at footnotes in this report connect with the ‘internet archive’ (otherwise known as ‘Wayback Machine’ or ‘Web.Archive.Org’) as opposed to the original location on Government websites. This protects against Government organisations restructuring their websites or removing documents which they later realise are ‘sensitive’ or embarrassing as they may reveal failings or cover-ups in their management of the pandemic[†]. This results in ‘broken links’. By linking to ‘web.archive.org’ instead of the original location, these web pages are preserved in perpetuity.

If you click on one of these links and encounter this message ‘**429 Too many Requests**’ it is most likely because you are using a VPN (Virtual Private Network) and may need to temporarily switch it off. This is because the web archive is seeing hundreds of requests all streaming through from one single place (an IP address) and is protecting itself against ‘bots’, by putting up this defence. Sometimes you may get an error message “**401 Authorization Required**”. Be assured that no authorisation is required. It is a glitch with the internet archive which usually resolves by refreshing the screen, open in a new tab or wait a few minutes and try again.

[†] **Example of Officials ‘airbrushing’ Websites in order not to conflict with IPC guidance on masks**

By way of example, HSE had some web pages with safety advice for healthcare workers caring for patients with very serious diseases such as SARS (the outbreak which occurred in 2002-3). The virus which caused that disease (now known as SARS-CoV-1) is virtually identical to the virus which causes COVID-19 (SARS-CoV-2) in its physical characteristics and in the way it transmits between people. Therefore the requirements and capabilities of physical devices (masks/respirators) needed to filter it effectively and prevent both these viruses infecting a person are also identical. This is just simple, basic science. If FFP3 is needed for one, an FFP3 is needed for the other.

A CATA member wrote to Ms Sarah Albon, Chief Executive of the Health and Safety Executive on 24 March 2022 ¹⁶ pointing out that, for the past two years of pandemic, HSE guidance and IPC guidance were completely at odds with each other i.e. HSE was specifying FFP3 respirators and IPC was specifying surgical masks.

Within a few days of that letter, HSE hastily removed the page (<https://www.hse.gov.uk/biosafety/diseases/sars.htm>) so, when clicked, it will now return a ‘Page Not Found error 404’. However, they cannot hide from “Wayback Machine”. The ‘resurrected’ page may be found here: <https://web.archive.org/web/20210418031034/https://www.hse.gov.uk/biosafety/diseases/sars.htm>;

Until the cause and route of transmission are known, in addition to standard precautions (sometimes known as universal precautions), infection control measures for inpatients should include:

- Airborne precautions, eg
 - Either an isolation room with negative pressure relative to the surrounding area or a single room with own bathroom facilities, and
 - Use of FFP3 filtering masks conforming to EN 149:2001 for persons entering the room. This equipment must be face-fit tested before use.

When HSE first posted the above web page (1 July 2004) the route of transmission of SARS had not been fully established. That is why it says “Until the route of transmission is known”. However, by 2013, it was well known that SARS was an airborne disease, transmitted by aerosols and larger droplets and that FFP3 respirators would therefore be required. This is evidenced in a paper published in 2013 ¹⁷, co-authored by Professor Jonathan Van-Tam and Dr Lisa Ritchie.

Extract from paper published in the Journal of Hospital Infection					
Table 1 Commonly encountered infections and their routes of transmission					
Pathogen	Disease	Immunization (refer to appropriate immunization guidance, e.g. ‘Green Book’ in UK ¹⁷)	Main route of transmission	Respiratory personal protective equipment for healthcare workers	
				Surgical face mask required	FFP3 required
SARS coronavirus	Pneumonia	Not available	Droplet/aerosol		FFP3 for AGP required ¹
					(recommended to be worn until patient is no longer considered infectious)

Nothing had changed between 2013 and the arrival of the pandemic in 2020. SARS-CoV-1 and its ‘sibling’ SARS-CoV-2 were both airborne/aerosol transmitted diseases. As stated by Dr Jones in his oral evidence, citing World Health Organisation, “no virus has ever been shown to change its mode of transmission”.

¹⁶ Letter to Sarah Albon, CEO, HSE : Section 2.1 (page 3) draws attention to HSE guidance on SARS/FFP3 ([Link](#))

¹⁷ Guidance on the use of respiratory and facial protection equipment, Coia et al ([Link](#))

2. The first challenge to the IPC Cell's guidance on PPE (22 December 2020)

It should be noted that much of the evidence supporting this section has been gathered by Freedom of Information requests to public authorities including DHSC, NHS-England and UK Health Security Agency.

NHS-E and UKHSA were particularly unhelpful, seemingly unwilling to render up the information requested, often only doing so when instructed by the Information Commissioner's Office that they must. This has all the hallmarks of a widespread cover-up and/or a reluctance to release information which may be helpful to litigants in the Court proceedings expected to move ahead during 2026.

Even at the time of finalising this report there are still outstanding FoI requests which are long overdue. This may be due to the fact that they are specifically concerned with the actions of UKHSA Senior Management such as Prof Susan Hopkins during her role of COVID-19 Incident Director for Public Health England when pressure appears to have been exerted upon the PHE members of the IPC Cell to withdraw their proposal to extend the use of FFP3 respirators to all healthcare workers (clinical and non-clinical). It was hoped that it may be possible to establish what pressures were exerted on whom and by whom, but the 'wall of silence', delays and prevarication have thwarted these attempts. Only the Inquiry has the power to answer these questions. It is hoped that they will.

Due to redaction by the public authorities, names of individuals cannot be disclosed unless that information is already in the public domain. The following convention will be used to facilitate reading of the narrative:

- **[Cell]** means a senior member of the IPC Cell (but not a PHE representative).
 - This may refer to Dr Lisa Ritchie (Chair of the Cell, likely to have been the main contact with DHSC and PHE at this time). Alternatively, it may refer to Prof Mark Wilcox who was present at the meeting on 22 December and, as a Director of IPC in NHS England, was senior to Dr Ritchie.
 - However the Inquiry should satisfy itself on this point by requiring unredacted copies of the evidence if it does not already have them.
- **[PHE]** means one of the PHE Experts who were members of the IPC Cell.
 - May include Dr Colin Brown, Dr Renu Bindra, Dr Catherine Heffernan, Dr Misha Moore or Susie Singleton
- **[DHSC]** means any person in DHSC. It should, however, be noted that DHSC redaction policy is less stringent than the other public authorities and the names of senior officials are not redacted. In those instances the names of the individuals will be given below.

It must be emphasized that no assumptions must be drawn as to the identity of persons identified by the above convention [Cell], [PHE] and [DHSC].

In this section the following aspects will be considered:

- The recommendation by PHE experts to extend the use of FFP3 and similar respirators more widely in view of the increased evidence available of airborne transmission;
- The IPC Cell collectively overrides PHE and refuses to accept their 'precautionary approach'.
- **[Cell]** misrepresents the outcome of the Cell meetings, reporting to senior figures in DHSC that a 'consensus' has been reached when a 'consensus' had most certainly **not** been reached.
- **[Cell]** alters the official minutes of the 22 Dec meeting, changing consensus from "precautionary approach for high risk pathways" (i.e. wider use of FFP3) to "no change in PPE/RPE" and removes points that members had made concerning a move towards FFP3. (See section [2.4.1](#) below).
- DHSC confirm that, if the PHE proposal went ahead to provide FFP3 respirators in all high risk areas / "red areas", then there were sufficient stocks available in the country to support this, with increased UK production now resulting in less dependency on imports.

2.1. Background

At its module 3 public hearings, the Inquiry discussed events which occurred at the Cell meeting on 22 December 2020, questioning several state witnesses at length. This was the meeting at which Dr Colin Brown (Public Health England) proposed to extend the use of FFP3 respirators to all healthcare workers across the four nations of the UK who provided care to suspected or confirmed infectious patients. At that time, these life-saving devices were restricted to relatively few HCWs carrying out medical procedures known as Aerosol Generating Procedures (AGP).

He and other experts in Public Health England considered that there was sufficient evidence of airborne transmission to justify this measure as a precautionary approach since FRSMs do not protect the wearer against inhalation of airborne viruses. However, the remainder of the IPC Cell did not agree and the proposal was rejected.

This was at the height of the second wave of the pandemic when the more transmissible 'Kent'/Alpha variant was spreading fast. Vaccines had just been approved but not yet rolled out, leaving doctors, nurses and other HCWs exposed and vulnerable to a highly pathogenic pandemic virus which was fast spreading across the country.

Of all the members of the IPC Cell, Dr Brown was arguably the most highly qualified, competent and experienced¹⁸. His views should not have been given short shrift by Cell members. His own senior management within PHE failed to give support, not just to him, but to his like-minded colleagues in the IPC Cell.

Public Health England was designated the United Kingdom's lead authority for pandemic emergencies in the UK and their recommendations should have been respected and carried more weight within the Cell.

It is CATA's contention that if the PHE proposal for extending the use of respirators had been implemented, then the deaths and severe injury to the health of innumerable HCWs could have been avoided. In turn, onward transmission from frontline HCWs to others (patients, co-workers, HCW families) would have been reduced. The AGP Alliance (fore-runner of CATA) had lobbied hard for a change in the IPC guidance on behalf of 100,000 HCWs it represented. However, its representations were repeatedly ignored. Requests for a meeting were repeatedly delayed by DHSC, taking over 5 months to arrange. That meeting is discussed at section 4 below.

It is hoped that those responsible[†] for the decision to reject Dr Brown and colleagues' advocacy for a precautionary approach should be further questioned about the events outlined in this section, since not all the facts emerged during the public hearings in the autumn of 2024. It will be a matter for others to decide whether any state bodies or individuals should be held to account in terms of litigation or disciplinary measures.

[†] *This includes some members of the 4-Nations IPC Cell (not necessarily all) and it certainly involves those in more senior positions within the NHS, Public Health and DHSC officials superior to the IPC Cell who may have connived to suppress Dr Brown's initiative.*

It appears that state bodies failed to disclose certain highly relevant documents to the Inquiry. If so this will have not only hampered the investigations by Counsel to the Inquiry (CTI) but denied core participants relevant information to which they have a right of access and restricted their ability to propose pertinent 'rule 10' questions to be put to witnesses at the public hearings.

If it is found that documents referenced in this report were not disclosed by the state bodies to the Inquiry, then the Inquiry should use its powers to obtain these documents (unredacted) together with any other documents which may also have been withheld. The Inquiry would need to do this:

- (a) in order to properly satisfy the terms of reference set to the Chair by the Prime Minister; and
- (b) because the hundreds of bereaved families and injured HCWs are entitled to have the **full** facts revealed in the public domain about what happened during those dark days. It would be a travesty if, at the end of this Inquiry which has placed such demand on the public purse, if crucial questions remain unanswered at the end of it.

¹⁸ Dr C Brown: **Qualifications:** BSc (Medical Sciences), Bachelor of Medicine, Bachelor of Surgery, MSc (Epidemiology), Diploma in Tropical Medicine and Hygiene, Diploma in HIV Medicine, Fellow of the Royal College of Pathologists
Field Experience: Infectious Diseases Advisor for the King's Sierra Leone Partnership (KSLP) during the Ebola outbreak in West Africa. Provided practical outbreak management and clinical leadership in Ebola holding units.

The FoI requests have turned up around 100 individual emails in threads which are (as usual) ordered with the most recent ones first. The most relevant emails have been extracted from these and are reproduced below in chronological order, so as to facilitate reading. These are formatted in blue italic text. Any dagger annotations (†) have been added in order to provide additional explanation/commentary i.e. they were not present in the original email.

Individual URLs are not given but, if required for verification purposes, they may be found at the links to the WhatDoTheyKnow website via the footnote below.¹⁹ To save time downloading, CATA will be happy to provide PDF versions to the Inquiry and Core Participant legal teams upon request.

2.2. Public Health England sets out its position on airborne transmission and RPE

Prior to the Cell meeting on Tuesday 22nd December 2020 PHE were firming up on the position they would take regarding airborne transmission and the need for better protection for HCWs in high risk areas such as ‘red wards’ with cohorted infectious patients.

This was documented in an internal email that was sent to a senior PHE official by Dr Colin Brown, seemingly on behalf of his colleagues, the other IPC specialists who represented PHE at the IPC Cell.

Sent: 22 December 2020 20:44

■ will raise this tomorrow on your call but we have reached a new decision point for IPC/PPE, based on conversations we had on Monday and again today on the IPC Cell call and after. SOS[†] has asked for an update (below) and IPC Cell are garnering opinion (attached).

[†] Secretary of State (Rt Hon Matt Hancock MP)

Our feelings for an PHE agreed position are:

1. There is increasing evidence for a recognition of aerosol transmission from a variety of non-AGP settings, including coughing/high volume voice (which would apply to sick individuals and respiratory vocalisations) in settings where ventilation is limited, as is the case in many NHS facilities due to inherent challenges with built environment. The direction of face covering recommendations also reflects this.
2. There is increasingly evidence that the new variant has higher viral loads and hence any aerosols/droplets produced will have more infectious virus.
3. There has been a rapid review of COVID-19 healthcare worker sickness absence in EoE/London/SE, this suggests trends are in keeping with community transmission; nosocomial acquisition is higher in northern areas reflective of increased numbers of COVID-19 patients and inherent issues with architecture of NHS buildings – this is reassuring – however there are reports of increased outbreaks in hospital wards and among staff caring for COVID-19 patients in a manner not seen before across London/SE; whether this is due to breaches of PPE or whether the variant is causing infection ‘despite of’[†] current PPE, or a reflection of increased community exposure, is unknown.
[†] The ‘quote marks’ suggest that the sender of this email considers current PPE (i.e. FRSM) to be ineffective.
4. Therefore sessional use of FFP3 masks should be recommended for those caring for suspected and confirmed patients, pending a time-limited review (weekly) of available evidence on novel variant and evaluations of whether increased outbreaks and transmissions reported are due to inadequate use or ‘breakthrough’ of current PPE – this will be coordinated through HOCl and NHS IPC regional leads
 - a. Opinion was divided on whether this should be done in isolation or with the full AGP PPE (including gowns, eye protection)
 - i. This approach does not delink the AGP PPE, felt by some to be a key difficulty with only recommending FFP3 use
 - ii. The gowns would likely need to be changed between each patient posing significant additional resources and being a considerable change
 - iii. Just using FFP3s outside of non-AGPs was felt by some to be appropriate as the major route of exposure is inhalation, and if fit-tested they provide better droplet protection also
5. As we are in a period of sustained increase and high prevalence, and given test results are still not timely in many areas, some would argue for FFP3 use in all settings. However we know that those who are asymptomatic are considerably less infectious with regards to transmission potential; messaging would reinforce wearing of FFP3 masks for all suspected patients with compatible symptoms and for all cadres of staff attending to them e.g. radiographers, porters.

¹⁹ Links to ‘WhatDoTheyKnow.com’ sources: [Link1](#), [Link2](#), [Link3](#), [Link4](#), [Link5](#), [ICO Notice served on UKHSA](#), [UKHSA Response to Notice](#)

6. Staff in other areas wearing T2R[†] masks (and not FFP3) would not need to self-isolate if exposed to patients who turn out to be positive later in admissions; there is a recognised risk to those in these settings (where patients may be earlier in illness and have higher viral load) however the burden of risk is in suspected/confirmed settings and PPE would be targeted accordingly.

[†] type IIR fluid resistant surgical masks

7. There should be a review of green pathways across Tier 4 pathways (or wider) - all staff should be wearing PPE (T2R, gowns, gloves) for all patient encounters.

8. There will need to be parity across primary care (poor ventilation in GP surgeries, etc) and particularly social care, which would need to be rapidly worked up with PHE and DHSC ASC Cells, including fit testing and ideally consistency of supply chain to ensure that this does not need to be done more than once. This would also ensure appropriate sectoral risk/benefit analysis e.g. communicating with agitated residents in care homes.

9. There will need to be careful communication and engagement with key stakeholders e.g. how to mitigate more widespread FFP3 use as a barrier to communication for patient safety, and how to mitigate against staff safety issues in emergency situations such as trauma calls, operating theatres, cardiac arrests, obstetric emergencies

It should be noted that the above email was sent **after** the IPC Cell meeting of 22 December 2020. However, it is clear that this had been discussed internally within PHE during the days leading up to this pivotal Cell meeting. The email mentions that it was **“based on conversations on Monday”** (i.e. either Mon 14th or 21st Dec, prior to the meeting on Tuesday 22nd).

The email also says it was based on discussions **“on the IPC Cell call”** and therefore gives insight into some of the arguments which PHE may have put to the Cell during the meeting, although not recorded at that level of detail in the minutes.

The following day [Dr Brown] was asked to prepare a ‘Formal Evidenced Proposal’ setting out the PHE position. This was communicated to [DHSC] and [Dr Ritchie] by email:

Sent: 23 December 2020 12:21

Subject: Re: Urgent: Advise on FFP3 masks

We have been asked by our senior leadership team to draft a formal evidenced proposal for their sign off on our position for input, apologies, this will take a little time but we aim to have something for sign off by tomorrow.

[Dr Brown], assisted by his team of IPC specialists, duly prepared the ‘Formal Evidenced Proposal’ summarising the technical evidence supporting the move to wider deployment of RPE.²⁰ It is not necessary to repeat the report here as it can be read via the link in the footnote below. Suffice to say that it was a cogent, well-expressed paper providing a balanced perspective on the issues involved which supported their recommendation:

“We therefore recommend the sessional use of FFP3 masks for staff caring for suspected and confirmed patients in non-AGP settings, where additional controls of hierarchy such as increased ventilation, cannot be immediately improved.”

This ‘Formal Evidenced Proposal’ will be discussed in section 2.8 below as there are a lot of questions about its fate, apparently being suppressed by PHE Senior Management following communications between Prof Mark Wilcox (IPC Director, NHS England) and Prof Susan Hopkins (COVID-19 Incident Director, PHE).

2.3. ARHAI sets out its position on airborne transmission and RPE

2.3.1. The credibility of ARHAI technical information is called into question

In preparation for the Cell meeting on 22nd December ARHAI produced a “Rapid Review of the Literature” relating to the Kent/Alpha Variant VUI-202012/01 which may be found at the link below.²¹ This was presented by Laura Imrie. It most likely had a very strong and persuasive influence on the members, particularly the conclusion **“There is currently insufficient evidence to ascertain if infection control precautions need to be altered in response to the emergence of the new COVID-19 strain VU 202012/01”**.

²⁰ Formal Evidenced Proposal : The use of FFP3 respirators for all suspected and confirmed COVID-19 patients in non AGP settings, PHE (23 Dec 2020) ([Link](#))

²¹ ARHAI: Rapid Review IPC for COVID-19 specific for variant VUI-20201-01 (Kent/Alpha Variant) presented at IPC Cell meeting 22 Dec 2020 ([Link](#))

2.3.1.1. Incorrect and misdirecting reference to European (ECDC) technical information

The ARHAI paper considered the ECDC²² Threat Assessment Brief²³ and reproduced some of the key points. ARHAI stated ***“In regards to infection prevention and control ECDC’s recommendations reflect those of current guidance”***. That statement was absolutely untrue and misdirecting. The ‘threat assessment brief’ made no mention of IPC at all. Neither did it touch on the question of mitigations for healthcare settings. Although it gave general advice on non-pharmaceutical interventions in a public ‘health’ sense (avoid unnecessary travel, curtail social activities, lockdowns etc) this was not, in any sense of the word, “IPC” as regards the matters under consideration by the IPC Cell.

In order to provide an open, transparent and informative account of the European position on PPE/RPE, ARHAI should also have referenced the extant ECDC document “Technical report : IPC for COVID-19 in Healthcare Settings”, 6 October 2020.²⁴ This document set out the European guidance, **specific to IPC**, in parallel to this review of the variant. The IPC document was regularly updated in line with advancing knowledge of the disease.

If ARHAI had been doing its job properly it would have made the following statement instead:

“In regards to infection prevention and control, current UK IPC guidance falls far short of ECDC’s recommendations for HCW protection. ECDC state ‘Healthcare workers in contact with a possible or confirmed COVID-19 case should wear a well-fitted respirator and eye protection’.”

One can only speculate why ARHAI did not volunteer this information. Their reticence may have been due to the European IPC guidance being more comprehensive, providing far better protection for their HCWs than the UK.

One might argue that ARHAI were having to react at pace to the emergence of the new variant and may therefore be excused if some omissions were made. However, that excuse cannot apply here. This edition of the ECDC technical guidance (version 5) had been in place since 6 October 2020. In fact the ECDC move towards respirators was introduced as early as May 2020 in version 3 of the guidance.

ARHAI produced monthly ‘rapid reviews’ to inform the IPC Cell and others. Their December edition²⁵ was woefully out of date, still referencing ECDC version 2 (March 2020). ARHAI were obviously keeping an eye on ECDC publications as they cited references from later publications but seem to have omitted evidence which showed UK IPC guidance was deficient in comparison to Europe’s.

It is interesting to note that PHE were more ‘on the ball’ and had reviewed the up-to-date ECDC/IPC technical document (version 5, Oct 2020) and noted the clear evidence of airborne transmission via the findings of viral RNA in a variety of hospital settings including air outlet fans which could not be explained via the ballistic droplet theory.

2.3.1.2. Incorrect and misdirecting reference to NERVTAG technical information

NERVTAG held an emergency meeting on 18 December 2020 to discuss the Kent/Alpha Variant.²⁶ Dr Lisa Ritchie and Dr Colin Brown were both at the meeting so would both have had a clear understanding of what took place.

ARHAI correctly referenced the NERVTAG statement and noted:

- ***“VUI-202012/01 demonstrates a substantial increase in transmissibility compared to other variants”;***
- ***“The variant demonstrated exponential growth during a national lockdown”.***

However they failed to mention that NERVTAG were unable to draw any conclusions as to the mechanism(s) underlying this increased transmissibility. This is important.

When one combines the 3 factors flagged up by NERVTAG: (a) “substantial increase in transmissibility”, (b) “scientific uncertainty regarding the underlying mechanisms causing this increase”, (c) “reduction in direct contact between people through lockdown” then this ought to have raised red flags, increased suspicions of airborne transfer and implementation of the ‘precautionary principle’ – which is precisely what PHE were advocating.

²² The European Centre for Disease Prevention and Control

²³ ECDC: Threat Assessment Brief: Rapid increase of a SARS-CoV-2 variant ... in the UK (21 Dec 2020) ([Link](#))

²⁴ ECDC: Technical Report : IPC and preparedness for COVID-19 in healthcare settings, 5th Update (6 Oct 2020) (page 6([Link](#)))

²⁵ ARHAI: Rapid Review IPC for COVID-19 version 9.0 (4 Dec 2020) – Reference to superseded IPC guidance – page 70, reference 416 ([Link](#))

²⁶ INQ000128575 : NERVTAG Meeting (18 December 2020) ([Link](#))

Under ‘references’ at the end of their rapid review, ARHAI referenced a paper by the SAGE Environmental Modelling Group (EMG) (4 Nov 2020) which concerned various methods of mitigating airborne transmission of COVID-19.²⁷ This paper absolutely confirmed the airborne transmission route of COVID-19. It wouldn’t have been written and accepted by SAGE otherwise. The inclusion of this link shows that ARHAI had this particular document available to them in December 2020 and therefore knew, or should have known, the certainty of airborne transmission (hence the need for airborne precautions), but failed to mention this highly relevant fact to the IPC Cell. This evidences ARHAI’s propensity for selecting evidence that was helpful to their position on the one hand and their systematic exclusion of inconvenient evidence on the other. In fact they withheld this EMG information from their monthly reviews right through until October 2021.

2.3.1.3. A consideration of the different routes of SARS-CoV-2 transmission in hospital settings

Prof Mark Wilcox outlined the findings of a paper produced by a subgroup of SAGE called SPI-M (Scientific Pandemic Influenza Group on Modelling), reporting that the predominant transmission is ‘patient-to-patient’. Although not mentioned in the minutes, it is noted, in the paper itself, that this could be attributable to a number of factors including airborne transmission. This, if it was mentioned in Prof Wilcox’s presentation to the Cell would surely have been a strong indicator to everyone present that airborne precautions (FFP3) should be deployed and lent support to PHE’s position advocating wider use of FFP3 respirators.

The SPI-M report attributed less significance to ‘patient-to-staff’ transmission, suggesting it was “low” and that PPE usage mitigated the risk. As with any computer program, it is only as good as the data and processing instructions fed into it by humans. It is probable that the model used for this work was the same one used by Stephanie Evans, Prof Mark Wilcox et al in a paper on the topic of nosocomial transmission²⁸, published as a pre-print in October 2021.²⁸

²⁸ ‘nosocomial = Healthcare Acquired Infection (usually meaning hospital-acquired)

This was the paper upon which Dame Ruth May relied in her witness statement for the incredible claim that “IPC measures reduced HCW infections by around 51% in wave 1”. Some commentators might argue that the 12,000+ nosocomial deaths in England and the 2,000+ in Wales during the first two COVID waves, together with the HCW fatality rate being one of the highest in the world, seriously undermine the credibility of this claim and the reliability of the computer model that was used.

The data, algorithms and processing logic that have been programmed into this computer model should be reviewed, since ‘real-life’ studies using genetic sequencing have demonstrated that ‘patient-to-staff’ transmission was between 20 - 25% in waves 1 and 2.²⁹ This is not “low” by any stretch of the imagination. If extrapolated across the UK, it would likely have accounted for tens of thousands of HCW infections.

It is important to recognise that the research mentioned above was carried out in 2021 i.e. after the IPC Cell meeting under consideration here. These concerns have been mentioned in order to flag up that future reliance upon such computational models should be treated with caution unless properly calibrated against real-life data such as Whole Genome Sequencing. This should now be possible, given the large amount of sampling and analysis during the COVID-19 pandemic.

Interestingly though, the studies using genetic sequencing do indeed confirm that ‘patient-to-patient’ transmission was by far the most predominant route (as correctly confirmed by Prof Wilcox at the start of the meeting). Given that fomite (contact with surfaces) transmission is very rare and, on the whole, patients will not have been subject to ballistic droplets landing directly on their face from other patients’ coughs and sneezes, ‘patient-to-patient’ transmission is a persuasive indicator of airborne transmission. This was comprehensively explained by Professor Beggs in his written and oral evidence presented to the Inquiry.

²⁷ SAGE/EMG paper : Potential Application of Air Cleaning devices ... to Manage (Airborne) Transmission of COVID-19 (4 November 2020) ([Link](#))

²⁸ “Efficacy of interventions to reduce nosocomial transmission ... : A computational modelling study”, Evans, White, Wilcox, Robotham (29 Oct 2021) ([Link](#))

²⁹ Characterising within-hospital SARS-CoV-2 transmission events, Lindsey et al (19 July 2021)([Link](#))

It is CATA's contention that ventilation and air quality (in terms of airborne pathogens) is critical to the prevention of nosocomial infection, just as the provision of RPE (not surgical masks) is critical to the prevention of HCW infection when providing direct, close-quarter care where general room ventilation has little effect. HCWs simply do not have the options available to them for social distancing and isolation as is the case out in the community and may spend whole sessions in contact with infectious patients. As such, they were exposed to the highest levels of exposure to the virus of any profession in the country. Since the level of impact on one's health is proportional to the level of exposure to a hazardous substance (i.e. concentration of airborne virus in this case, coupled with length of time exposed), it is unsurprising that so many HCWs developed such serious and life-changing consequences from Long-Covid.

2.4. The IPC Cell meetings : 22nd and 23rd December 2020

These meetings, were explored in detail by the Inquiry at the module 3 public hearings. Counsel to the Inquiry brought out the key points in questioning of Barry Jones, Lisa Ritchie, Ruth May, Susan Hopkins and Laura Imrie. This has been well recorded in the transcripts.³⁰ This report expands on the events of those few days around Christmas 2020 and records evidence that the Inquiry may not yet have been able to consider due to documents having been withheld from it by the public authorities.

In summary, the key points which attracted the Inquiry's interest were the recommendations by Dr Colin Brown and Dr Eleri Davies to adopt a more precautionary approach regarding the provision of FFP3 and other respirators to HCWs. They also noted concern that, if the Cell recommended a different approach to PPE, it may be tantamount to an admission that they had got it wrong back in March 2020 when the 'step-down' from FFP3 to FRSM occurred. The fact that Dr Ritchie had been a key player in the introduction of that 'step-down' guidance in March was not lost on CTI. It was noted that, at the meeting on 23rd December, the member representing Northern Ireland was concerned that if the PPE recommendations changed, NHS staff may feel that they have not been sufficiently protected in the past, following the stepdown from FFP3 to FRSM back in March. An element of what may be described as 'back-covering' seemed to be creeping in.

2.4.1. The integrity of IPC Cell minutes is called into question : 'Airbrushing' to suit a narrative?

Evidence exists which suggests that the minutes of these meetings were altered by [Cell] in order to avoid discovery of having misled senior officials within DHSC and possibly even the Secretary of State and the Chief Medical Officer.

It goes without saying that the minutes of important meetings should provide an accurate reflection of what actually occurred and not be distorted. This is especially true during a national emergency such as a pandemic. If a person were to alter the minutes in order to save professional embarrassment or to suit a personal narrative, then that would be quite wrong – possibly to the extent of being considered "misconduct in public office".

First we will examine the minutes taken for the meeting on 22 December when PHE introduced their recommendation for the 'precautionary approach' where the consensus was recorded as being "no PPE/RPE change". In fact this was not what the scribe from the NHS-E Secretariat had recorded in the minutes. As can be seen in figure 1, certain adjustments were made to the minutes. This could only have happened on or after 6th January when the Secretariat emailed the draft minutes out to members, including [Cell].³¹ Those minutes recorded that the consensus was for the 'precautionary approach' recommended by Dr Colin Brown. Figure 1 below allows a comparison of the 'draft' and 'final' versions of the minutes. It is reasonable to assume that the person taking the minutes will have recorded an accurate version of events as they took place.

³⁰ Module 3 Transcripts : Barry Jones ([Link](#)), Lisa Ritchie ([Link](#)), Ruth May ([Link](#)), Susan Hopkins ([Link](#)), Laura Imrie ([Link](#)), Matt Hancock ([Link](#))

³¹ Email (6 Jan 2021) from NHS Secretariat to Chair & members of IPC Cell attaching draft minutes of meetings 22nd / 23rd December 2020 ([Link](#))

IPC Cell Meeting (22 Dec 2020) : Comparison of Notes

OFFICIAL-SENSITIVE	
Meeting Date & Time	IPC Cell Discussion 22 December 2020 – 10:00-11:30
In attendance:	Lisa Ritchie, NHSEI (Chair), NR , NHSEI, NR , NHSEI/David Cunningham, AACE/Laura Imrie, ARHAI Scotland/Eleri Davies, PH Wales, NR , NR , NHSEI/Catherine Heffernan, PHE, NR , PH Wales, NR , NR , HSC NI, NR , PHE, NR , NHSEI/Jackie McIntyre, NHSEI/Colin Brown, PHE/Debra Adams, NR , NHSEI/Mark Wilcox, NHSEI, NR , NHSEI, NR , NHSEI, NR , NR , NHSEI, NR , NR , NHSEI, NR , PHE/Renu Bindra, PHE/Misha Moore, PHE, NR
INQ000398244 Significant Changes Made: Key: Text deleted _____ Text inserted _____	
(1) ORIGINAL DRAFT	■ - There is a challenge with managing quarantine bays. We need to be clear when masks should be worn, as there has been an assumption that patients would not have to wear masks in bed. <u>Should staff have FFP3 masks in Covid wards?</u>
AMENDED VERSION	NR - There is a challenge with managing quarantine bays. We need to be clear when masks should be worn, as there has been an assumption that patients would not have to wear masks whilst in bed.
(2) ORIGINAL DRAFT	■ - We need to decide what evidence we are going to measure against and what intelligence we will use. ■ - we should use nosocomial data against community prevalence and do investigations into incidents. If there is high staff anxiety about the new strain, should we consider using FFP 3 masks? ■ - There will be pressure from organisations and bodies for more precautionary measures. The faith of staff in high intensity units is being lost. If there is a high-risk pathway, we should take precautionary measures. <u>In Wales renewal teams are moving to using FFP 3 masks.</u>
AMENDED VERSION	LI - We need to decide what indicators we are going to measure against and what intelligence we will use. ED - There will be pressure from organisations and bodies for more precautionary measures. The confidence of staff in high intensity units is being lost. If there is a high-risk pathway, we should take precautionary measures.
(3) ORIGINAL DRAFT	■ - Patients in high risk areas do you have symptoms, therefore FFP3 masks could be worn in these pathways.
AMENDED VERSION	JM - Patients in high risk areas (<u>AGP hot spots</u>) are more likely to have symptoms, therefore FFP3 masks could be worn in these pathways.
(4) ORIGINAL DRAFT	■ - <u>the consensus seems to be a more precautionary approach for high risk pathways.</u>
AMENDED VERSION	LR – <u>We appear to have consensus:</u> - that face masks for patients should be strongly recommended, and patients should be provided with a new mask every day or more often if required - on the importance of rapid testing and limiting patient movement with hospitals - on patient education on mask wearing - on reviewing data on staff positivity and ongoing review of emerging evidence/science and data to inform IPC guidance <u>On the question of whether we need to change recommendations on the level of PPE/RPE - there does not appear to be available evidence that the PPE/RPE level currently recommended in the IPC guidance should change at this time.</u>

Figure 1: A comparison of draft minutes recorded by NHS-Secretariat with Final version edited by [Cell].

For convenience, links to the two versions are provided in the footnotes: ³² ³³

³² IPC Cell Minutes : Draft (as obtained via Freedom of Information Request) (22 December 2020) ([Link](#))

³³ IPC Cell Minutes : Final Version (as submitted to the UK Covid-19 Inquiry) (22 December 2020) ([Link](#))

For clarity, a summary of the changes illustrated in fig 1 are as follows (*using the reference numbers in the margin*) :

- (1) **Deleted:** A Cell member raises a question/suggestion that staff in Covid wards should have FFP3 respirators.
- (2) **Deleted:** A Cell member indicates there may be a high level of anxiety amongst staff about the new variant and suggests a move towards FFP3. The whole paragraph is deleted including the (very sensible) suggestion about comparing nosocomial data with community prevalence and do more investigations into incidents.
- (2) **Deleted:** Dr Eleri Davies' comment that the supply teams in Wales are already moving towards FFP3s.
- (3) Jackie McIntyre's recommendation that FFP3s be worn in high risk areas was **edited** by the additional words "(AGP hot-spots)".

This point about adding "AGP hot spots" does not bear scrutiny. It was already a requirement that airborne precautions be implemented for "AGP hot spots". This had been the case since version 1.0 of the 4-Nations IPC guidance was introduced on 13 March 2020:

In light of the above, the Department of Health and Social Care's New and Emerging Respiratory Virus Threat Assessment Group (NERVTAG) have recommended that airborne precautions should be implemented at all times in clinical areas considered AGP 'hot spots' e.g. Intensive Care Units (ICU), Intensive Therapy Units (ITU) or High Dependency Units (HDU) that are managing COVID-19 patients (unless patients are isolated in a negative pressure isolation room/or single room, where only staff entering the room need wear a respirator).

Figure 2: Extract from section 2.1, 4-Nations IPC Guidance version 1.0, 13 March 2020

Dr Ritchie would have known this since she was heavily involved in preparing that guidance for publication.

Ms McIntyre would also have known this, so was hardly likely to recommend that guidance could be changed to include FFP3s in these settings when that had already been the case for the past 9 months. It therefore appears possible that: (a) Ms McIntyre's intention was for FFP3s to be worn in all high risk pathways (regardless of AGPs); and (b) This idea did not find favour with [Cell].

When considering the possible falsification of these minutes, it must be acknowledged that the scribe from the NHS Secretariat may have mis-recorded the discussion. However, this would have meant that they had heard things which weren't actually said (i.e. the deletions made at items 1 and 2), so this seems unlikely.

One therefore has to question why [Cell] might want to adjust the minutes in this way. Possible reasons are given in the following sections, but in summary:

- Shortly after the meeting had finished on 22nd December, [Cell] had informed a considerable number of important people in DHSC who were fact-finding for Secretary of State Matt Hancock, that a consensus had been reached at the Cell meeting that morning and it had been agreed that the PPE/RPE guidance would **not** be changing.
- So, when the draft minutes arrived in [Cell]'s Inbox after the Secretariat had returned from the Christmas break, it must have been awkward to see the consensus recorded as adopting the precautionary approach recommended by Dr Brown. These minutes may subsequently be seen by those same senior officials who had been told about the 'consensus' for no change.

It is unusual to have access to the draft minutes as well as the final minutes so that one can identify alterations which have been made. Of the approximately 120 IPC Cell minutes disclosed to the Inquiry, this is the only one where we have draft and final versions. The researcher who managed to obtain these draft minutes is to be commended for his remarkable perseverance. It took him 17 months to elicit them from a public authority reluctant to yield them up – and then only when ordered to do so by the Information Commissioner's Office.

There is only one other meeting (8 Dec 2021) where independent notes are available to compare with the official set. These were made by PHE representatives of their contributions to the meeting – which also differ significantly from the official set of IPC Cell minutes. Unfortunately both documents are subject to Inquiry confidentiality rules and cannot be disclosed in this report.

We can, however, deduce that it was not only the minutes of the 22nd December 2020 which were altered but also those of 23rd December.³⁴ Comparing the final paragraph of the 22nd with the 4th paragraph on the 23rd we find this:

22nd Dec: LR – We appear to have consensus: ***on the question of whether we need to change recommendations on the level of PPE/RPE – there does not appear to be available evidence that the PPE/RPE levels currently recommended in the IPC guidance should change at this time.***

23rd Dec: The consensus from yesterday's discussions ***on the question of whether we need to change recommendations on the level of PPE/RPE was that there does not appear to be available evidence that the PPE/RPE levels currently recommended in the IPC guidance should change at this time.***

These must have been inserted on or after 6th January as both sets of draft minutes were attached to the same email.³⁵

There appears to be sufficient similarity between the two sentences to suggest that “copy/paste” has been used. It is apparent that the format of the two sets of minutes are noticeably different, with the 22nd being plain text and the 23rd being tabular. This suggests that they were written by two different people using different templates. The chances of two people having used the self-same wording is virtually impossible. Applying this text to the minutes of the 23rd implies that a ‘consensus’ had been reached the previous day when, as discussed below, this was not so.

The question which therefore arises is what else may have been ‘adjusted’ in the minutes of the meeting of the 23rd since the same pressures will have been on [Cell] which necessitated the changes being made for the 22nd. Without sight of the Secretariat’s original draft we cannot tell. The Inquiry may wish to obtain this for comparison purposes.

As regards the alleged “consensus” at the 22 Dec meeting we can estimate the proportion of members in favour of the precautionary approach by examining draft minutes (before alteration by [Cell]). There were 22 members present.

- All 4 PHE representatives presumably supported the precautionary approach;
- Dr Eleri Davies and Jackie McIntyre appeared to be in favour of wearing FFP3s in high risk areas;
- The member who spoke about the problems managing quarantine bays seemed to be leaning that way too.

So that makes 7 in favour so far.

- the member who mentioned staff anxiety and moving towards FFP3 also seemed like-minded. However, that person also mentioned measuring nosocomial data vs community prevalence so it is possible that person could have been one of the 4 PHE members, which may have made them a target for removal of the whole item.

So we have 7, possibly 8 of the 22 members recorded in the minutes supporting the precautionary approach.

There were several who didn’t seem to venture an opinion one way or another and there was no sign of a ‘showing of hands’.

So, with a third (or more) of members supporting the precautionary approach this can hardly be considered a “consensus” however one interprets the word. Certainly, as the evidence in the following sections demonstrates, the PHE representatives came away from the meeting with a clear opinion that consensus had not been reached and [Dr Ritchie] did, in the end, have to agree that was the indeed the case (see section 2.5.1 below).

Further evidence is available which suggests that Dr Brown’s proposal was actually given quite serious consideration by Cell members at the meeting on the 22nd. His proposal appears to have been discussed in some detail. The evidence for this can be seen in Dr Brown’s long email sent to senior manager which was reproduced in section 2.2 above (i.e. the email sent 22 Dec, 20:44).

He reported that, when they were discussing the sessional use of FFP3 masks for the care of all suspected and confirmed patients, differing opinions were advanced as to how this would best be achieved. Some members thought that the provision of FFP3s could be done in isolation. Others thought that full AGP PPE (including gowns and eye protection) may be needed.

³⁴ INQ000398242 : Minutes of ‘IPC Cell Huddle’ (23 December 2020) ([Link](#))

³⁵ Email from NHS Secretariat to Chair and Members of IPC Cell attaching draft minutes for meetings 22/23 Dec 2020 (6 Jan 2021) ([Link](#))

He reported that some members expressed the opinion that just using FFP3s on their own (without gowns and eye protection) would be appropriate for non-AGP scenarios as they felt that “***the major route of exposure is inhalation and FFP3s also provide better protection against droplets***”.

This detailed level of discussion really does not sound like a meeting that was heading towards a consensus of “no change to PPE”. It supports the original record of the consensus as being in favour of the precautionary approach rather than the ‘adjusted’ consensus.

2.4.2. Ambiguities around the word ‘consensus’ : The roles of the IPC Cell and Public Health England

Dame Ruth May was the Senior Responsible Officer for the 4-Nations IPC Cell. In her oral evidence she described the IPC Cell as “a consensus group” and in her written statement (paragraph 234) that:

- “the Cell worked collaboratively on a consensus basis”; and
- “the Cell made recommendations and provided draft content for the UK IPC Guidance, which was then passed to PHE/UKHSA for comment and publication approval”.

We need to consider these in more detail:

1) Did the Cell work collaboratively on a consensus basis?

- Judging by the repeated opposition by some members towards PHE and resistance to the expert advice they were seeking to impart to the Cell, a better descriptor would be combatively than collaboratively.
- As regards “consensus” the problem is that the word can mean different things to different people.

The derivation and meaning of the word “consensus” is derived from the Latin word “consentire” = “to feel together”. So, to some people, it means a “meeting of minds”, “mutual agreement” or “agreement by all”. To others, as clearly the case here, it means “agreement by most”. This ambiguity probably lies at the heart of the matter.

- If the meeting of 22nd December is anything to go on, the evidence seems to suggest that in practice the group did not really act as a “consensus group”. The evidence suggests that the consensus appears to have been heavily weighted in favour of the views held by the Chair herself and her like-minded colleagues with whom she had worked at NHS Scotland and ARHAI who were adamant that surgical masks were good enough protection and they would not be moved from that position under any circumstances.

2) Was the IPC Guidance passed from the IPC Cell to Public Health England for “comment and publication approval” as stated by Dame Ruth in her oral evidence?

- It is true that IPC guidance was published by PHE as they undertook the physical uploading of the documents to gov.uk website. However, it was not PHE/UKHSA’s role to ‘approve’ the guidance before publishing it and Dame Ruth knew this well.

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Dr Ritchie, in her oral evidence, explained that, in the event of a failure to reach consensus, the matter would be escalated to senior leaders (such as Chief Medical Officers, Chief Nursing Officers, senior Public Health officials etc) who could have over-ruled the IPC Cell and published differing guidance.

Looking at this from a different perspective, when the IPC Cell puts out a statement that something has been agreed “as a consensus”, the CMOs, CNOs and Public Health officials would see no need to take a contrary decision in view of there being a 4-nations’ agreement amongst “IPC experts” (as they referred to them).

When Counsel to the Inquiry asked Dr Ritchie whether she could remember any occasions where any CMO, CNO or Public Health bodies had ever come back and said "You need to make a change to this guidance or we're not going to approve it in its current form", she could not recall any such occasions and went on to accept that the recommendations reached at the UK IPC Cell were all routinely incorporated into the national guidance. Despite careful scrutiny of all the documents disclosed by the Inquiry, no evidence has been found of any challenge or 'push-back' against IPC Cell decisions ever resulted in any change to PPE/RPE guidance.

During Dr Ritchie's oral evidence under oath, CTI questioned her about the 'consensus', as recorded at the end of the notes of the Cell meeting on 22nd December, since the point about not changing PPE/RPE fell outside the bullet points. CTI thought that this might be interpreted as not being part of the 'consensus'. It read as follows:

LR – We appear to have consensus:

- that face masks for patients should be strongly recommended, and patients should be provided with a new mask every day or more often if required
- on the importance of rapid testing and limiting patient movement with hospitals
- on patient education on mask wearing
- on reviewing data on staff positivity and ongoing review of emerging evidence/science and data to inform IPC guidance

On the question of whether we need to change recommendations on the level of PPE/RPE - there does not appear to be available evidence that the PPE/RPE level currently recommended in the IPC guidance should change at this time.

Dr Ritchie twice confirmed that this **was** part of the 'consensus'. Her confirmation on this point strongly suggests that the addition of this text was by her own hand.

2.5. The afternoon of 22nd December 2020 – ‘behind the scenes’ with DHSC

2.5.1. DHSC is Informed that the IPC Cell has decided PPE/RPE will not be changing

At lunchtime, soon after the Cell meeting had ended there was a discussion between [Dr Ritchie] and colleagues in the PPE Policy & Strategy Directorate of DHSC to inform them of the PHE proposal. DHSC had oversight of the arrangements for provision of PPE across the country. Evidence that discussion took place can be seen in the following extract from an email sent by Mr Michael Dynan-Oakley (MDO) (DHSC’s Deputy Director, PPE Policy) at 15:28:

“I think what we need is them to confirm / flesh-out (perhaps), the understanding they gave us at lunch time of what is coming down the track on the IPC guidance; i.e. Guidance not changing at this time in respect of the PPE needed in different settings...”

(The full email thread is provided in full at appendix 1 and discussed in section 2.7 below).

It was absolutely right and proper that [Dr Ritchie] should brief DHSC colleagues about the proposal being put forward by Public Health England. There would obviously be implications on supply and demand.

However, it was absolutely **not** right and proper to have told them that the Cell had reached a consensus that the PHE proposal would not be implemented and there would be no change to the PPE/RPE requirements when no such consensus had been reached. At that time the proposal for extending the supply of FFP3s was still very much ‘on the table’ as evidenced by the detailed email being prepared by Dr Brown and colleagues (described in section 2.2)

It was not long before MDO and his colleagues discovered that [Dr Ritchie’s] assertion was untruthful and that no such consensus had been reached. We can tell this when a DHSC representative emailed [Dr Ritchie] and [Dr Brown] in the emails reproduced below, which began a few minutes later:

From: [DHSC] to [Dr Ritchie] and [Dr Brown]

Sent: 22 December 2020 15:39

Subject: FW: Urgent Advice on FFP3 masks

Thanks for the helpful update on the IPCG in today’s check-in. We’ve received an urgent request from SoS’ office on FFP3s. Can you please review the lines I’ve drafted below, to explain what is coming down the track on the IPC guidance:

Note: [DHSC] original email in blue text

[Dr Lisa Ritchie] embedded responses in the red text

[Dr Colin Brown] embedded responses in green text

- **IPC Guidance will not be changing at this point in time in respect of PPE needed in different settings; however the guidance will be kept under review as we know more about the variant. Agreed**

However, [Dr Brown] knew this not to be the case and added this text confirming that consensus had yet to be reached:

- **There are ongoing discussions around increasing the use of FFP3s in clinical areas where AGPs are not regularly being undertaken in the high risk pathway. If there is consensus from the UK IPC Cell for this approach, this will be included within the revised guidance due to be published within the next couple of days. This may accelerate the use of FFP3s, however, we expect some trusts will already be enhancing their approach to FFP3s for sessional use in Red pathways.**
- ~~There will be new comms around the existing pathways, the Red Pathway in particular, to highlight that sessional use of FFP3s is already in the guidance for workers exposed to known COVID-19 cases and AGPs, which may accelerate the draw on FFP3s a little as this existing guidance may not be closely observed across acute trusts; although. However, we expect some trusts will already be enhancing their approach to FFP3s for sessional use in Red pathways.~~ [Dr Ritchie] crossed out [DHSC]’s text above and commented:

To clarify, the sessional use of FFP3 respirators is not in the existing guidance. However, there was some discussion (at a UK IPC Cell meeting today) around increasing the use of FFP3 respirators in clinical areas where AGPs are not regularly being undertaken in the high risk pathway. A consensus position is being sought from the UK IPC Cell and will be revised in an update to the guidance this time round if they agree. The UK IPC Cell have been asked to comment on this by tomorrow midday.

Note: Text above highlighted to emphasise an important point

- i.e. [Dr Ritchie] clearly accepts [Dr Brown]’s point **that consensus had not yet been reached** and they are going to have to revisit this at the Cell meeting next day. The email from [DHSC] made it clear that the Secretary of State was personally involved in this issue, so it was conceivable that the earlier misrepresentation of a ‘consensus’ could reach the ears of quite important people.

2.5.2. Communications within the IPC Cell

Shortly afterwards, Dr Ritchie emailed all members of the IPC Cell:

22 December 2020 17:02

From: IPC-CELL

Subject: URGENT: UK IPC guidance consensus by 12md 23rd Dec 2020

Dear colleagues

Thank you for meeting today to discuss two papers (previously emailed) on SARs-CoV-2 VOC-202012/01:

- Rapid review of the literature SARS-CoV-2 variant VUI-202012/01: Implications for infection control within health and care settings
- SPI-M approved summary document: Estimating the importance of different routes of SARS-CoV-2 transmission in hospital settings

Based on the rapid review it was agreed that there is currently insufficient evidence to change the IPC/ PPE precautions in response to the emergence of this variant strain. The UK IPC Cell, PHE have agreed to continue to monitor and review the emerging evidence and data and if this situation changes amend the guidance accordingly. This rapid evidence review has not identified a change in the mode of transmission between this variant strain and previous circulating strains of SARS- CoV-2 and therefore it was agreed that there should be no changes to the PPE recommendations as currently set out in the guidance until more evidence/data is available.

However, there was some discussion around increasing the use of FFP3 respirators in clinical areas where AGPs are not regularly being undertaken in the high-risk pathway. In the recent round of revisions requested to the existing guidance, it was agreed the sessional use of FFP3 for 'AGP hot spot areas' was to be added.

Can you confirm by return (midday tomorrow) whether you wish to recommend the use of FFP3 respirators in the high risk pathway?

In relation to the SPI-M paper, it was agreed to strengthen the UK IPC guidance recommendation/ requirement for:

- The wearing of facemasks by all inpatients at all times across all care pathways, providing this is tolerated by the patient and ensuring this is not detrimental to medical/care needs.
- Highlight that adherence with the guidance must be considered across all Trusts/areas.
- Where possible (ensuring it is not detrimental to care) limit patient movement in hospital settings.
- Highlight the need for rapid testing particularly in high or increasing prevalence areas for staff and patients.

Kind Regards

Responses duly arrived from Cell members. The email from Public Health England was concise and to the point:

From: [PHE]³⁷ To: IPC CELL

Sent: 23/12/2020 11:39:33

OFFICIAL

Dear All, I would like to recommend the sessional use of FFP3 masks & visors for red/ high risk pathways (suspected and confirmed only). Long sleeved gowns should remain single use and for use with AGPs.

Kind Regards

This written response confirmed that there was still no consensus at the outset of the meeting.

Other responses were received from other members opposing the precautionary approach to move to wider use of FFP3, such as that received from Laura Imrie in which she denies there is any clear evidence of airborne transmission and mentions outbreak reports including one at a choir practice (referring to the Skagit choir). We will return to this in section [10.1](#) when discussing ARHAI's 'Rapid Reviews of the Literature' and their dismissal of the report published by the PHE experts in the Respiratory Evidence Panel since it challenged their 'droplet' dogma.

³⁷ Although one might make a reasonable guess as to who sent this email, no firm evidence is available due to redactions

2.6. The IPC Cell meeting : 23rd December 2020 : ‘No change in PPE/RPE’

As mentioned earlier [**Dr Brown**] would have been busy preparing the ‘Formal Evidenced Proposal’ for his PHE Senior Leadership Team and so was not able to attend the meeting. This was a shame as the outcome of the meeting may well have been different if PHE’s case could have been pushed persuasively. The minutes of the 2 meetings show attendance as being:

- 22nd December : 22 attendees, with 4 from representatives from PHE
- 23rd December : 14 attendees, with only 1 representative from PHE

Despite the redactions within these documents, it can be deduced that the one PHE representative attending on the 23rd had not been one of the four present the previous day so was (a) disadvantaged and (b) very outnumbered. As can be seen in the minutes of this meeting, when asked to present PHE’s position she said “***PHE are recommending FFP3 masks in all medium/high risk pathways (irrespective of AGPs) as there could be increased airborne transmission in these pathways***”.

When asked if PHE had evidence of increased airborne transmission she began to explain that the risk arose from evidence which derived from singing, shouting and in enclosed spaces. We must remember that these are only brief minutes and the Secretariat’s note-taker may have summarised a broader explanation in the draft minutes which, we have to remember, have been ‘adjusted’ by [**Cell**], later.

Only those present will know – unless these meetings were recorded, which may be an avenue that the Inquiry may wish to explore for these key meetings.

In any event, the minutes show that the PHE representations were quashed with what appeared to be a warning by Dr Eleri Davies “***We should be careful with the language we use around this***”. PHE, although not in the majority, were a critical stakeholder and the lead Department for the UK’s pandemic response.

2.7. Supply issues: Were there enough FFP3s available to support non-AGP care settings ?

This was an issue under urgent consideration within DHSC. The answer to the question is ‘YES’, though recognising that there was not an infinite stock of FFP3s and there would have to be some limitations.

As will be seen in the email chain at appendix 1, Secretary of State Matt Hancock asked the Department to advise him on current stock levels and assess the position if FFP3 respirators became “standard” in healthcare. The DHSC were confident that they could cope with this. There were sufficient stocks of FFP3s available in the country to have provided to those HCWs who were at the highest level of risk to be protected.

Matt Hancock, in his request to DHSC officials, did not amplify the meaning of “becoming standard”. However, it is clear from the email threads referenced below that officials took this to mean “High risk/red pathways”. These were described in the extant IPC guidance at December 2020 as follows:

Any care facility where:

- a) untriaged individuals present for assessment or treatment (symptoms unknown); or
- b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for; or
- c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results; or
- d) symptomatic individuals who decline testing.

Insofar as it is possible to tell from the email threads, it appears that DHSC were calculating the increased demand for FFP3 to cater for supply to staff in the high risk / red pathways. A non-exhaustive list of such locations was given in the IPC guidance as follows:

- Designated areas within Emergency/Resuscitation Departments
- GP surgeries/walk in centres
- Facilities where confirmed or suspected/symptomatic COVID-19 individuals are cared for e.g.
 - Emergency admissions to in-patient areas
 - Critical Care Units
 - Mental health
 - Renal dialysis units
 - Maternity

No mention is made of PPE requirements for paramedics as this was covered in separate IPC guidance. However, if the spirit of extending PPE to all high risk/red pathway settings had been extended to paramedics they would have been issued with FFP3 when providing care to, or assessing suspected/confirmed patients within 2 metres and in ambulances.

As mentioned, the above list of high risk/red areas in the IPC guidance was cited as “non-exhaustive”. Logically the same protections would have been applied to community HCWs such as speech and language therapists, community nurses etc. However, no indication can be found as to whether this was within their thinking.

It must be appreciated that these discussions were being held in the context of intense lobbying by external stakeholders after the Prime Minister’s press briefing on 19 December 2020 during which he described the new variant as being up to 70% more infectious.

On 23 December 2020 Dame Donna Kinnair (Chief Executive & General Secretary, Royal College of Nursing) and Dr Chaand Nagpaul (Council Chair, British Medical Association) wrote to Sir Patrick Vallance, explaining that nurses and doctors were concerned about their increased personal risk of contracting the virus and doubts they had over the efficacy of the risk control and mitigation measures.³⁸ They asked for the precautionary principle to be applied in terms of increased PPE including a higher level of RPE for those working with patients suspected or confirmed as having COVID-19.

It is not known whether the RCN/BMA received any response. However it is known for sure that no action whatsoever was taken and the representations of these distinguished organisations representing around 610,000 frontline healthcare professionals were completely ignored and no action was taken to enhance protection of their health and safety.

One might have hoped that such a letter would have been drawn to the attention of the IPC Cell, if only to convey the extent of anxiety and concern by the people whose health, and indeed lives, were in their hands. Inspection of the minutes of the Cell’s next meeting (6 January 2021) show that the RCN/BMA letter was not even mentioned. At their following meeting (13 January) the minutes show that an open letter from the BMA to Prime Minister Johnson regarding the use of FFP3 respirators was discussed by Cell members. It was noted that PHE had received several other open letters regarding PPE. The Cell acknowledged that staff were anxious with regards to the new variant strains, but decided that it would be sufficient just to reiterate that droplet precautions (FRSM + eye protection) were considered effective for preventing transmission to healthcare workers.

It is important to recognise that if the Government had listened to experts such as Professor Paul Elkington at Southampton University during the first wave (April 2020) and taken up the offer by Jaguar Land Rover to mass produce powered respirators, then the healthcare sector would not have been so dependent on these uncomfortable tight-fitting FFP3 respirators. Professor Elkington wrote to Sir Stephen Powis (National Clinical Director) urging national take-up of the initiative.³⁹ However, this met with little interest and the initiative was not progressed at a national level. Southampton hospital continued development and, by the time wave 2 struck, over 3,500 of these life-saving devices were in use and very popular with staff who felt safe, secure and comfortable wearing them with their own personal supply of HEPA-filtered air.

Powered respirators are much more comfortable to wear. They fit all face sizes and shapes. They may be worn by men who wear beards or turbans for religious/faith reasons and crucially do not require fit-testing. With the backing of Jaguar Land Rover it was conceivable that by the second wave every single frontline HCW could have been efficiently protected.

³⁸ INQ000417588 Joint letter from the Royal College of Nursing and the British Medical Association to Sir Patrick Vallance (23 Dec 2020) as described in the witness statement of Rosemary Gallagher MBE ([Link](#))

³⁹ Email : Prof Paul Elkington (Southampton University) to Sir Stephen Powis (NHS England) advocating national implementation of personal powered respirator across the NHS (2 Apr 2020) ([Link](#))

Following the Secretary of State's request for information, DHSC officials were able to rapidly pull together the facts and figures he required. This can be seen from the flurry of emails which followed Matt Hancock's request. They clearly had their 'fingers on the pulse' of PPE supply.

The Department is to be commended for being able to provide the information so quickly and, indeed, for having restored stock levels so effectively since the difficulties the country had faced at the outset of the pandemic with worldwide shortages of respirators.

A timeline is provided at appendix 1 comprising 18 emails. It should be noted that none of these emails were disclosed to the Inquiry (*at least not in module 3*). They may have been disclosed during other modules (*to which CATA is not permitted access – a matter of considerable frustration*). The availability of FFP3 respirators at this critical juncture during the height of the second wave is a topic which is highly relevant to the healthcare sector. These emails ought, therefore, to have been disclosed to the Inquiry during module 3 and thence to core participants. That is why we have reproduced them appendix 1.

In summary:

- During the autumn of 2020, the Government had set itself a target of building up a stock of 35 million FFP3s, sufficient supply for 120 days (at the rate of demand at that time)
- By December 22nd it had far exceeded the target and had amassed a stockpile of 43 million FFP3s.
- UK manufacturing capability had been considerably strengthened in order to shield the country from global shortages and production rates were 13 million FFP3s per month.
- DHSC staff were modelling the impact of supplies if the use of FFP3s became standard in healthcare, as opposed to FFRMs. The final outcome of this modelling was not contained in the emails as the officials (understandably) felt that the Secretary of State needed an accurate, well-considered, response from the specialist modelling team rather than an 'ad-hoc' response. However, the general tenor of the emails suggested confidence that they could cope if FFP3s became standard (as described above).

2.8. PHE IPC experts stand their ground (only to be overruled by senior management)

We now look at the events of 23rd December 2020.

Despite the opposition encountered at the IPC Cell during the previous day's meeting, the IPC experts within Public Health England began to consolidate and justify their position. As discussed in [section 2.2](#) above, they had already informed senior management as to their agreed position which they felt the organisation should adopt. Now they needed to prepare a document for submission to the IPC Cell and DHSC formalising and justifying that position. They therefore began work preparing a '**formal evidenced proposal**'.

We can see this being requested in an email by a senior official in PHE:

23 December 2020 11:37

From: (redacted)

To: Colin Brown and (redacted)

Subject: OFFICIAL: FW Urgent: Advice on FFP3 masks

I think this needs a written brief with the evidence, the options and challenges with each option.

■ and I will need to sign off and ■ will need to see it - it needs to be balanced and correct as this is key decision.

This was communicated by Dr Brown to DHSC:

23 December 2020 12:01

From: [Dr Brown]

To: DHSC, [Dr Ritchie]

Subject: Re: Urgent: Advice on FFP3 masks

We have been asked by our senior leadership team to draft a formal evidenced proposal for their sign off on our position for input, apologies ■ this will take a little time but we aim to have something for sign off by tomorrow.

Dr Brown then arranged with colleagues to assist with the work:

23 December 2020 11:59

From: [Dr Brown]

To: 12 colleagues in PHE (redacted)

Subject: Re: Urgent: Advice on FFP3 masks

We need to do this today, but I have limited capacity this afternoon but can review.

■ can you start (unless (■ you think someone else) - can people send in evidence they have:

- ■ Evidence on aerosolisation
- ■ changes to face coverings and evidence review behind
- ■ relevant literature reviews
- ■ anything from a Trust level that is useful, even anecdotal
- ■ anything on the new variant and known/unknowns you can share that are not in meeting minutes.

The Formal Evidenced Proposal was therefore prepared during the afternoon. It can be read via the link in the footnote below.⁴⁰ It was a cogent, well-expressed paper providing a balanced perspective on the issues involved which supported their recommendation. It was far more comprehensive, covered a wider range of topics and was better supported with up-to-date references than the papers presented by ARHAI the previous day. It unequivocally recommended **“the sessional use of FFP3 masks for staff caring for suspected and confirmed patients in non-AGP settings, where additional controls of hierarchy such as increased ventilation, cannot be immediately improved.”**

However, Dr Brown was soon to become aware of looming problems. He was mindful that his colleague across in DHSC was anxious for information in order that she could update her managers. She had sent an email:

23 December 2020 12:10

From: DHSC

To: [Dr Brown], [Dr Ritchie]

Subject: Re: Urgent: Advice on FFP3 masks

Can I clarify, are we expecting a decision to be made tomorrow on the Red Pathway approach or will it take longer?

He updated her:

23 December 2020 16:01

From: [Dr Brown]

To: DHSC, [Dr Ritchie]

Subject: Re: Urgent: Advice on FFP3 masks

We'll have something to share with IPC Cell tomorrow signed off on our end.

To which she replied:

23 December 2020 16:50

From: DHSC

To: [Dr Brown], [Dr Ritchie]

Subject: Re: Urgent: Advice on FFP3 masks

I just spoke with ■ and ■ confirmed that the IPC Cell has today confirmed that there is currently insufficient evidence to change the IPC/PPE precautions in response to the emergence of this variant strain. Therefore there will be no changes to the PPE recommendations as currently set out in the IPC guidance until more evidence/data is available to the guidance.

Where does the PHE's formal evidenced proposal fit in with this and could this result in changes to the IPCG that is due to be published within the next couple of days?

This seemed pretty cut and dried. **“There will be no changes to PPE”**. Nevertheless, not to be thwarted, Dr Brown sent one last email before leaving for his Christmas break:

23 December 2020 17:32

From: Colin Brown

To: DHSC, [Dr Ritchie]

cc: Michael Dynan-Oakley (DHSC)

Subject: Re: OFFICIAL : RE: Urgent: Advice on FFP3 masks

We have not yet given our written proposal to the IPC Cell which is currently being worked on including evidence as presented at NERVTAG and we will have available tomorrow to share with the IPC Cell for them to consider.

⁴⁰ Formal Evidenced Proposal : The use of FFP3 respirators for all suspected and confirmed COVID-19 patients in non AGP settings, PHE (23 Dec 2020) ([Link](#))

It is regrettable that all of these emails were withheld from the Inquiry. It must be borne in mind that these emails would all have been held by **three** state bodies, not just one (namely UKHSA, NHS England and DHSC). It is remarkably suspicious that **not one of them disclosed these email threads to the Inquiry and suggests collusion**. Not only would this have enabled the Inquiry to see the unredacted versions of the above (*which could possibly have led to criticisms of conduct and the issuing of rule 13 letters*)⁴¹ but it also denied core participants access to relevant documents to which they have right of access.

Furthermore, that was the end of the “Formal Evidenced Proposal” – at least as written by Dr Brown and his team. He would not have been aware of this but various ‘behind the scenes’ discussions were taking place at senior management level. The “Formal Evidenced Proposal” just ‘disappeared into thin air’ until it surfaced again several years later when, in April 2024, it was disclosed to core participants at the COVID-19 Inquiry (INQ000408934) after being adduced into evidence by Dr Ritchie along with her written statement. We will return to this later since prima facie evidence exists to suggest that her evidence to the Inquiry was untrue and, of course, written statements are submitted along with a signed ‘statement of truth’ in which the signatory confirms that “they understand proceedings may be brought against anyone who makes a false statement...”.

As soon as this ‘Formal Evidenced Proposal’ was discovered amongst the Inquiry documents an investigation began which sought to discover what happened to it. That investigation, through Freedom of Information requests, began in July 2024 and, through the apparent intransigence of the public authority, well beyond the statutory response period of 20 working days prescribed by law, UKHSA has frustrated attempts to discover exactly what happened to the document, although a disturbing picture has already emerged, as discussed below.

The reluctance to yield up the information may be explained by the fact that some of the individuals likely to have been involved in the suppression of Dr Brown and colleagues’ proposals were still occupying senior management positions when the FoI arrived in mid-2024. Indeed some still are in senior posts.

The scope of the FoI requests included documentation such as emails which sent the ‘Formal Evidenced Proposal’ to DHSC, NHS England and the IPC Cell and any ensuing correspondence received in return.

The response from UKHSA did not include any of these emails and so an appeal was lodged (aka ‘internal review’).

Their response to the appeal was “**UKHSA does not hold information relevant to this part of your request, as the proposal document was not forwarded on as you have described**”. This did not seem to tally with the email mentioned above (23 December 2020, 16:01) in which it was stated that the proposal would be shared with the IPC Cell (and presumably DHSC also) the following day. Neither does it tally with Dr Ritchie’s witness statement (described above) where the ‘formal evidenced proposal’ apparently had a persuasive influence on the outcome of that meeting (i.e. no change in PPE recommendations).

Since the UKHSA response did not, on the face of it, appear to be entirely truthful, a complaint was lodged with the Information Commissioner’s Office, whose Senior Case Officer was incredibly thorough, painstakingly investigating what was quite a complex case. Consequently the ICO served a ‘Decision Notice’ requiring further action by UKHSA, warning that a failure to comply may result in contempt of Court proceedings.⁴²

In their response to this, the UKHSA gave the following explanation:⁴³

... as requested (by the ICO) UKHSA has conducted a fresh search of the author of the proposal’s email account, the relevant Clinical Guidance Cell account, and the relevant messages sent from the senior UKHSA official who took over discussions from the author of the proposal during a period of 5 working days annual leave. During the period of annual leave, the senior UKHSA official had amended the proposal and took this to senior management review. Approval of this revised approach resulted in the development of the Respiratory Evidence Panel (The role of face coverings in mitigating the transmission of SARS-CoV-2 virus: statement from the Respiratory Evidence Panel (2021) - GOV.UK)

⁴¹ ‘Rule 13 letters’ are letters sent by the Inquiry Chair to any person who may be subject to criticism in any report. This gives that person the opportunity to respond to the issues raised.

⁴² Information Commissioner’s Office : Decision Notice vs UK Health Security Agency (14 August 2025) ([Link](#))

⁴³ UKHSA Response to complainant in response to ICO Decision Notice ([Link](#))

However, it is important to note that this did not result in the proposal referred to above being directly sent back by email to the NHS IPC Cell as described in 3). Our fresh searches have therefore not located an email to the NHS IPC Cell as described in 3).

By way of a simple explanation: After the author for the Formal Evidenced Proposal (presumed to be Dr Colin Brown) left work on the afternoon of 23rd December (*having sent the above email to DHSC at 16:50*) he went on his well-earned Christmas leave for 5 days. His “Formal Evidenced Proposal” was then taken over by a ‘Senior Official’ and amended (one might say ‘as soon as his back was turned’). Instead of implementing the proposal, no action would be taken and a “committee” would be formed to review the evidence.

That committee (the Respiratory Evidence Panel) did not even get underway until March 2021 and took over 6 months to produce its final report, at which point the ‘experts’ in ARHA1 totally dismissed its findings and no action was taken by the IPC Cell to reflect its findings into IPC guidance. However, this prevaricating and procrastinating manoeuvre successfully met the objectives of the IPC faction which was so strongly opposed to the wider provision of FFP3 to our healthcare workers in their hour of need.

As one would expect, no indication was given as to the identity of the ‘senior official’ who took over and amended the ‘Formal Evidenced Proposal’. Dr Colin Brown’s line manager at the time was the Director of the National Infection Service (Professor Isabel Oliver). However, given their close functional and professional links, the next most senior official to have oversight of Infection Prevention and Control and senior management liaison with NHS-England and DHSC would most likely have been Professor Susan Hopkins, PHE COVID-19 Incident Director. CATA would welcome clarification of this point should the professor wish to volunteer a full account of these events in the interests of openness and transparency.

A consideration of other emails obtained via FoI provides useful insight into the thinking of PHE senior management at that time. Although names are redacted, references to attendance at SRG, (PHE’s Strategic Response Group) and persons ‘signing documents off’ demonstrate that these emails were passing between quite senior managers or directors.

During the evening of 22nd December, having received Colin Brown’s detailed email from the PHE IPC team setting out their agreed position, reproduced at section [2.2](#) above (*i.e. sent 22 Dec 20:44*), a senior manager (member of SRG) forwarded it onwards with this email:

Sent: 22 December 2020 21:00

The point I want to raise at SRG is the PHE contribution to IPC policy and whether the starting point – in terms of written advice/contribution from a technical agency – should be what we believe is optimal, including a possible precautionary approach at this stage, rather than what is achievable. We can negotiate reasonable compromises subsequently with stakeholders and NHSE, but I really do think we should be doing more like what CDC did from early on this year i.e. state what is best (even if precautionary), then what is the next best thing when that cannot be achieved e.g. because PPE supplies are insufficient.

As you know, the IPC guidance is still seen by many as being owned by PHE, even though it isn’t.

Another manager responded :

Sent: 22 December 2020 22:26

*SRG would be the right place to get our thinking and tactics clear on your questions. **Above all we should not get isolated in handling this.***[†] *Good to see that the NHS are doing some of the early evaluation of changes in transmission rates in their settings (Colin’s email) but social care will be a headache.*

[†]*emphasis added to convey the importance of this point.*

This is a very revealing comment which suggests, on the face of it, that the officials are less concerned with the safety of frontline healthcare workers and more concerned with political tactics, inter-departmental relationships and perhaps the standing of PHE in relation to its sponsoring Government Department (DHSC) and with the NHS.

We should now consider the oral evidence of Professor Hopkins given to Lady Hallett at the Inquiry on 18 September 2024. Because of the redactions applied to the emails obtained by FoI it is impossible to be certain which senior managers were involved in which email threads. This would not be the case if the emails had been disclosed to the Inquiry, whose redaction policy would mean these names would be left unredacted. So the following paragraphs in this subsection must be preceded by the comment that **IF** Professor Hopkins was involved in these email threads then some of the oral evidence given under oath at the Inquiry was, at best, misleading or, at worst, untrue. The Inquiry is invited to request the unredacted emails and other associated evidence to determine whether this is, in fact, the case.

Counsel to the Inquiry was asking Professor Hopkins about the minutes of the IPC Cell meeting:

- Q. When it says "a precautionary approach to move to FFP3 whilst we are awaiting evidence should be advised", what evidence was it that you were waiting for?
- A. ... I would say that I don't know exactly what CB (*Dr Colin Brown*) was thinking in this meeting and I don't know what it was.
- Q. Can I ask you this, why was PHE recommending a precautionary approach at this stage of the pandemic when it didn't do so in March 2020?
- A. So I think this was an individual recommending it.
I think it's really important that individuals come to meetings and raise a wide variety of components.

Her response reflects a trend amongst state witnesses which was noted in the earlier report "Changes in Management of COVID-19: 13 March 2020" (p.14) i.e. that they all sought to distance themselves from key decisions and events and attribute responsibility to other people, seeking to deflect responsibility (and accountability) from themselves.

Here we have a senior official (now CEO of UKHSA) seeking to have the Inquiry believe that this was just a personal 'one-off' view by Dr Brown alone. The evidence strongly suggests otherwise. It seems certain that all 4 of his colleagues who represented PHE at the IPC Cell shared the same view. The three present at the meeting on the 22nd did not speak against the precautionary approach and the one representative who attended the meeting on her own on the 23rd 'held the same line'.

So the question has to be asked as to whether Professor Hopkins was aware of her IPC team's 'agreed position'. Given that Dr Brown's detailed email (22 Dec 2020 20:44) was sent to a member of the Strategic Response Group (SRG), it is a reasonable assumption that the professor was the recipient of this email. If not, the recipient said that he/she was going to take it to SRG of which the professor was chair. Given the content of the two emails reproduced above (21:00 and 22:26) it is inconceivable that the professor would not have been aware of Dr Brown's email which began "**Our** feelings for an agreed PHE position are: (*set out in 9 bullet points*)" which was sent to 2 recipients and 6 on the cc: list (likely to have been his team). This was most certainly not a 'lone wolf' expressing a personal opinion. He was representing his team's collective view which they hoped their organisation would corporately support. It should be noted that his colleague who attended the meeting on 23rd December, when asked to "**present PHE's position**" she responded "**PHE are recommending FFP3 masks in all medium/high risk pathways (irrespective of AGPs) as there could be increased airborne transmission in these pathways**". This demonstrates that she had not received any instructions from PHE senior management to take an alternative stance.

By seeking to disassociate herself from 'the precautionary approach' Professor Hopkins does herself (and her organisation) a great disservice. The implication of not being cautious about matters of life and death, strongly implies a reckless, cavalier approach with little consideration for the potential health consequences for well over a million healthcare NHS and social care workers.

In any event, given her role of Incident Director, coupled with the fact that this issue was likely the most urgent decision faced by PHE on that day, (particularly having stemmed from the Secretary of State), it would be extraordinary if she was not fully appraised of the situation – including all the technical details, 'pros and cons'. That was her job. As a consultant in infectious diseases and microbiology with a solid background in epidemiology and public health she would (and should) have been equally aware of the emerging science relating to aerosol transmission as Dr Brown clearly was. The evidence suggests that they had previously discussed this together.

Before moving on from the events of 23rd December, we need to look again at the witness statement of Dr Ritchie since there are some curious anomalies to be resolved.

In her witness statement ⁴⁴ Dr Ritchie stated:

“On 23 December 2020, PHE produced a report titled Use of FFP3 respirators for all suspected and confirmed COVID-19 patients in non AGP settings [INQ000408934], which stated (in relation to the emergence of the Alpha variant) that “there is currently no substantive evidence to suggest that the new variant has a different mode of transmission, other than it being more transmissible.” This was discussed by the Cell on that same day [IN0000398242] and the minutes confirm that there was consensus that in the absence of evidence of a different mode of transmission there should be no change to guidance.”

First, before considering the accuracy and reliability of Dr Ritchie’s witness statement, anyone who cares to compare the above paragraph with the actual PHE ‘Formal Evidenced Proposal’⁴⁵ will immediately recognise that this one sentence has been carefully chosen because it gives the appearance of supporting the case for denying extended use of RPE. It even infers PHE’s support for this approach. She selectively ignores the rest of PHE’s proposal document which strongly supports extending the use of RPE. As an ‘aside’, as Dr Barry Jones insightfully observed during his oral evidence to Lady Hallett, all parties were quite correct, the route of transmission had not changed. It had always been airborne and nothing had changed in that respect as these various variants emerged. He also observed that although the minutes of the IPC Cell meeting noted “LR – We appear to have consensus” that could not be the case since the Cell Chair had overruled Dr Colin Brown’s proposal. His challenge to the veracity of the minutes has been proven correct by the findings set out at section [2.4.1](#) above.

A brief reminder of the timeline of events on 23rd December (as evidenced by Fol emails):

11:37	A PHE Senior Manager instructs Dr Brown to prepare a written brief with the evidence
11:59	Dr Brown enlists the help of his IPC colleagues and “divvies up” the work
12:00-13:30	According to Dr Ritchie’s witness statement to the Inquiry, the IPC Cell discussed this document at the meeting and this influenced the consensus among Cell members not to change the PPE elements of the guidance.
17:32	Dr Brown emails Dr Ritchie and Michael Dynan-Oakley (DHSC) confirming that they are still working on their proposal, which will be available the next day to share with IPC Cell.

The self-evident problem is that is that the document which Dr Ritchie says the Cell discussed at their meeting hadn’t yet been written. This dovetails in with section [2.4.1](#) above where it was noted that the minutes of both IPC Cell meetings (22nd and 23rd Dec) had been retrospectively amended on or after 6th January.

This calls into question the suitability of Dr Ritchie as a witness and the accuracy and reliability of her evidence (both written and oral). In the next section we turn our attention to the position that NHS-England were adopting in all of this, from which we get an impression of the pressure likely being brought to bear on PHE.

One other issue was discovered which suggests a lack of propriety in respect of document preparation. Following the IPC Cell meetings an “IPC Position Statement” was prepared. This can be accessed at the link below.⁴⁶

It is noted that references to Public Health England, their representations for a precautionary approach and the evidence which they presented are all conspicuous by their absence. Reference to the IPC Cell meeting and the consultation exercise carried out by Dr Ritchie on 23rd December are summarised as follows:

Following the IPC-Cell meeting, the four devolved administrations were asked (email ) to confirm if they wish to recommend the wider use of FFP3 respirators (in the absence of AGPs). The consensus view was, with no reported change in the evidence/science, there was no basis to support changing the UK IPC guidance at this time (Wales - email ) Scotland - email ) NI - email ) and Ambulance Services- email )

One might have hoped that the author of the position statement would have appreciated that there are only three devolved administrations, not four. Albeit perhaps a trivial point, but one which reflects a lack of detail and peer-

⁴⁴ INQ000421939_0046 para 172: Witness statement by Dr Lisa Ritchie (page 46, para 172).

⁴⁵ Formal Evidenced Proposal : The use of FFP3 respirators for all suspected and confirmed COVID-19 patients in non AGP settings, PHE (23 Dec 2020) ([Link](#))

⁴⁶ Position Statement (SBAR) on current IPC guidance and use of PPE for new COVID-19 variant strain (6 Jan 2021) ([Link](#))

review. The key point here is that there is no mention of the fact that Public Health England were invited to respond to this consultation exercise and did respond via the email sent to the IPC Cell at 11:39 on 23rd December, recommending the sessional use of FFP3 masks & visors for red/high risk pathways (suspected and confirmed only).⁴⁷

Furthermore, if we look at page 4 of the Position Statement, we note that the author has embedded 8 emails received back from IPC Cell members with their responses to the consultation exercise. Of course they cannot be clicked and opened as this is just a scan:

<u>Emails:</u>			
 (Scotland)  RE URGENT UK IPC guidance consensus b	 (Scotland)  RE URGENT UK IPC guidance consensus b	 (NI)  RE URGENT UK IPC guidance consensus b	 (Wales)  RE URGENT UK IPC guidance consensus b
  Ambulance Services  RE_OFFICIAL_ New Variant - Review of IP	Email   FW_ OFFICIAL_ New Variant - Review of IP	Email   URGENT UK IPC guidance consensus.n	<u>Meeting notes</u> <u>22/12/2020</u>  Notes from today's meeting.msg

However we can tell that the email received from Public Health England has been excluded as its filename/subject title: “**OFFICIAL: RE: URGENT: UK IPC guidance consensus by 12md 23rd Dec 2020**” is not amongst the 8 emails embedded into the document.

This does present a rather unbalanced view, concealing the fact that the consensus was by no means unanimous, with the views of Public Health England (the lead authority for the pandemic emergency in the UK) having been filtered out. This, together with the other evidence discussed in this section, suggests an unhealthy and systemic bias pervading the IPC Cell, paying scant regard to the experts in PHE.

⁴⁷ Email: Public Health England to IPC Cell: Response to consultation re extending the use of FFP3 respirators (redacted) ([Link](#))

2.9. NHS-England take a firm line AGAINST the extension of FFP3s to ‘red’ high risk areas

Once again, Freedom of Information requests have turned up emails (again, withheld from the Inquiry) with the subject line “Lines for Leaders”. These give insight into the way NHS England leadership viewed the issue of extending the use of FFP3s to staff beyond AGPs.

One might be excused for thinking that the NHS, with its founding ethical principles and legal duty to prevent ill-health and save lives, would be the first to support the wider provision of efficient protective equipment to its staff. However, the evidence suggests that this was not the case – or at least amongst the key decision-makers with power and influence in the IPC world. For reasons which are difficult to comprehend, they seemed set on ensuring that the initiative proposed by PHE was not going to happen. It is unclear whether they were under pressure from any other parties (political or medical) to take this stance. However, if this was the case, they have had their opportunity to clarify their position when providing evidence to the Inquiry even though this might constitute ‘whistle-blowing’, an ongoing contentious issue in the NHS.

It was, by now, apparent that some trusts had recognised the flaws in the IPC guidance and begun to provide proper RPE for frontline staff (e.g. Southampton and Addenbrookes) and, as Dr Eleri Davies had mentioned at the Cell meeting, the Welsh PPE renewal teams were now supplying FFP3s.

The following emails were exchanged, 29-30 December as NHS leaders developed the wording to be used when messaging leaders in ‘Lines for Leaders’ text.

The first email was sent at the request of Dame Ruth May (Chief Nursing Officer, NHS England)

29 December 2020 17:18

From: [Sue Tranka] (NHS-E Deputy Chief Nursing Officer – Safety & Innovation)

To: DHSC, [Prof Mark Wilcox] (National Clinical Director for IPC)

Subject: Lines for leaders bulletin

In light of trusts taking individual decisions to increase the PPE requirements, the lines below have been pulled together to Trust leaders to make the position clear as of the latest review on the 23rd December.

■■■■ would like your views and clearance on the wording below please:

IPC response to new variant strains

A peer review has been undertaken to assess the new variant strains (SARS-CoV-2 VOC-202012/01 and UK VOC122020/02) by an expert group of clinicians. The evidence review has not identified a change in the mode of transmission between the variants and previous circulating strains of COVID-19, and therefore a consensus agreed that there are no changes to the recommendations set out in the IPC guidance at this stage.

A [CAS alert](#) was issued on 24 December outlining actions for the NHS to take in response to the variants. All NHS organisations should ensure thorough application of current IPC recommendations and assurance on adherence, PPE is available and in supply, and that all staff training is up to date.

PPE should continue to be worn as per current IPC guidance; extended use of FFP3 masks is not advised. COVID measures in the workplace should be robustly implemented and adhered to, including reinforcing physical distancing, greater patient mask use and enhanced **decontamination/cleaning (especially frequently touched surfaces)**. **Local assurance should be obtained for optimised compliance with IPC measures.**

Emerging evidence and data on variant strains will be continually monitored and reviewed, and the guidance amended accordingly if needed.

This was then sent to PHE for comment. According to Dame Ruth May’s witness statement this was likely to have been sent to Prof Susan Hopkins:

30 December 2020 10:52

From: [Prof Wilcox]

To: [Prof Susan Hopkins?]

Subject: RE: Lines for leaders bulletin

Thank you for the very helpful discussion this morning. I reported our discussion, including that you agreed with the draft wording of the communication in the email below, at the national IPC team meeting this morning led by ■■■■

Following your meeting with ■■■■ later this morning, please could you send me (a reply to all) message confirming that PHE is content with the wording in the message below.

The email was then circulated within PHE

30 December 2020 13:12
From: [Prof Susan Hopkins?]
To: [Dr Brown?] + 4 other PHE colleagues

Apologies again for having to move this morning's meeting. Having discussed with [REDACTED] just now we propose the following changes (in blue):

IPC response to new variant strains
A peer review has been undertaken to assess the new variant strains (SARS-CoV-2 VOC-202012/01 and UK VOC122020/02) by an expert group of clinicians. The evidence review has not identified a change in the mode of transmission between the variants and previous circulating strains of COVID-19, and therefore a consensus agreed that there are no changes to the recommendations set out in the IPC guidance at this stage. The Scientific Advisory Group for Emergencies (SAGE) has also advised that there is currently no evidence of any association between the new variant and increases in transmission in particular settings and that there is no evidence for differences in routes of transmission or different survival on surfaces.

A CAS alert was issued on 24 December outlining actions for the NHS to take in response to the variants. All NHS organisations should ensure thorough application of current IPC recommendations and assurance on adherence, PPE is available and in supply, and that all staff training is up to date.

PPE should continue to be worn as per current IPC guidance and at present FFP3 masks are not advised outside of this guidance. This position is being kept under close review. COVID measures in the workplace should be robustly implemented and adhered to, including reinforcing physical distancing, optimising ventilation, greater patient mask use and enhanced decontamination/cleaning (especially frequently touched surfaces). Local assurance should be obtained for optimised compliance with IPC measures.

Emerging evidence and data on variant strains will be continually monitored and reviewed, and the guidance amended accordingly if needed.

From the context described in the previous subsection of this report, it is likely that the following email exchange was with Dr Colin Brown who had just returned from his Christmas break to discover that his initiative had been overruled by his senior management.

30 December 2020 13:41
From: [Susan Hopkins?]
To: [Dr Brown?]
Did you have anything to add to the email?

30 December 2020 14:28
From: [Dr Brown?]
To: [Prof Susan Hopkins?]
Please take my name off this as it does not reflect my stated position, as I said I am happy if this is a PHE position but it is not my own (which is what the briefing note reflects)

2.10. Who's in charge here? A complete breakdown in governance

Browsing through emails obtained via Freedom of Information a couple of emails were particularly noteworthy. These were emails from the Director General of Public Health in the Department of Health and Social Care. These emails were sent on the 22nd December 2020 following the Secretary of State's request for information for FFP3s and while the DHSC was waiting for news about the possible changes in IPC guidance to extend the use of FFP3s:

22 December 2020 12:22
From: Private Secretary to Jonathan Marron
To: (redacted)

In case you know: Jonathan would like to know who is leading on the actual guidance changes? Deputy Chief Nurse?[†]
Anyone else?

[†] Ms Sue Tranka

Clearly no answer was provided as he found it necessary to repeat the question the next day:

23 December 2020 09:38
From: Jonathan Marron
To: Michael Dynan Oakley and 5 others

... Also helpful to be very clear on the process for agreeing the IPC guidance and who signs off.

No answer was provided in the ensuing email thread. Note: This is not intended to be a criticism of Mr Marron. It is cited as an example of what was clearly a mystery to many people in senior positions in Government.

Throughout the pandemic, CATA members were appalled that no one in Government knew who was making crucial decisions about the level of PPE/RPE and ‘signing off’ the IPC guidance.

CATA’s experience and learning during the pandemic is that the arrangements in Government were chaotic:

- The Government messaging about disease transmission was mixed and confusing, with it being airborne in public information videos shown on TV, but it was not treated as airborne in healthcare;
- from time to time the virus astonishingly managed to change its behaviour as it crossed Hadrian’s Wall into Scotland with different mitigations applying between the two countries – neither of which worked;
- CATA wrote to Prof Sir Chris Whitty believing that, as Chief Medical Officer, he was the ultimate authority on medical matters and responsible for ensuring that these matters were quickly resolved and adequate protections put in place for healthcare personnel. In a single paragraph of reply we learned that it was not his job. This was down to the public health authority (PHE then UKHSA) and passed it to Prof Susan Hopkins;
- it took Prof Hopkins over 4 months to figure out how to reply to this relatively simple question, left until after the IPC Cell had been disbanded. She informed us that:
 - while the IPC Cell existed it was not PHE/UKHSA’s responsibility. It was the IPC Cell’s responsibility as a 4-nations group. PHE/UK’s only responsibility was to publish their IPC guidance on the Government’s website; and
 - after the IPC Cell was stood down it was still not PHE/UKHSA’s responsibility. It was the responsibility of the 4 individual nations via their National IPC manuals;
- However, Dr Lisa Ritchie told the Inquiry that the IPC Cell just drafted the IPC Guidance for sign-off by their Senior Clinical leaders (such as Prof Whitty, the other CMOs and the CNOs) who could have disagreed with any particular point and the IPC Cell would have then changed the guidance (although this never did actually happen);
- Insofar as CATA can determine, no one actually did ever sign off any edition of the IPC guidance (or will admit to doing so)
- Prof Whitty told the Inquiry that, when on the wards with COVID patients, he was “in the hands of the people whose professional job it is, which wasn’t his” and he just did as he was told and followed the guidance.⁴⁸ He also told the Inquiry that knowledge was extremely weak and no-one (presumably including those people in ARHAI/IPC Cell) could really put hand on heart and claim to be an expert – leading to genuine uncertainty. The only conclusions that can be drawn from this are that:
 - the people whom the Government repeatedly referred to as their ‘experts’ weren’t actually experts at all even though they thought of themselves as such (presumably a reference to the IPC Cell, IPC Director and ARHAI);
 - He hadn’t come across Dr Colin Brown, Dr Nathalie MacDermott, Dr Gillian Higgins or the host of other (real) experts who were trying to set the Government on the right path but were silenced or dismissed at every opportunity;
 - He would have undoubtedly come across Prof Cath Noakes since he had appointed her as co-Chair of the Environmental Monitoring Group which reported to him via SAGE. She was/is a real expert and was advising him about the airborne route of transmission;
 - He would have undoubtedly come across Prof Andrew Curran, the other co-Chair of EMG who is also an expert, but seemingly shackled by the HSE Management and Policy Directors that everyone in HSE must toe the Government line.

⁴⁸ Oral evidence of Prof Sir Chris Whitty at the UK Covid-19 Inquiry : pdf page 37, transcript p.144 L.23 ([Link](#))

- Prof Whitty described the confusion as to who was leading on IPC/safety, but was absolutely certain that it was not him or his team. This reflects Mr Marron’s uncertainty mentioned above. Nobody in Government knew who was in charge of this important area of healthcare worker safety.
 - It has to be said that legally the DHSC and its minister sat right at the top of the ‘chain of command’, being the host Department for its agencies PHE/UKHSA and the NHS which might best be described as a statutory arm’s-length body which is accountable to the Secretary of State/DHSC.
 - The conduct of DHSC and NHS-England, as described by Prof Whitty’s public admission (which most likely was mirrored in the devolved administrations) can best be characterised as a breach in the organisations’ duty of care to healthcare workers which falls far below what would reasonably be expected of the organisation (terminology which will undoubtedly be familiar to lawyers...)
- Sir Stephen Powis, (National Medical Director of NHS-E) believed that the guidance was drafted by PHE, then approved by NERVTAG, with the IPC Cell’s role being just to advise PHE on the operational implications of their decisions. He was mistaken in that NERVTAG never once reviewed or approved the IPC guidance.
- According to the witness statement of Professor Sir Peter Horby (Chair of NERVTAG)⁴⁹ ⁵⁰ NERVTAG’s only involvement with PPE and IPC was, on one occasion in February 2020, to make recommendations to SAGE regarding IPC measures to stop transmission including PPE for first responders and IPC guidance in secondary care. After that, all consideration of PPE and IPC passed to Public Health England and NHS England.
 - _____

 _____⁵¹
- Meanwhile the Health and Safety Executive who have an overarching statutory duty at a national level to protect worker safety (including healthcare workers) denied any responsibility for IPC:
 - HSE confirmed that they were “not involved in directing, influencing, or supporting PHE/DHSC policy and that HSE was not responsible for the guidance or approving the guidance”.⁵²
 - The sender of that letter (on behalf of the Chief Executive, Ms Sarah Albon) may have forgotten that HSE proactively assisted the health authorities in providing a “FAQ” document on 20 March 2020 which sought to convince HCWs that FRSMs would provide them adequate protection against the disease.⁵³ ⁵⁴
- From then on, the HSE turned a blind eye as the IPC Cell mandated ‘PPE’ that wasn’t actually PPE for the purposes of protection of the respiratory system, fully knowing that FRSMs would not protect the respiratory system. So healthcare workers, trusting and believing that they were protected, were lulled into a false sense of security, inhaled the virus, became ill and died.
- After HCWs became ill or died, HSE actively discouraged NHS Trusts and Health Boards from reporting occurrences of HCW illness or deaths from COVID-19 and refused to accept such reports.⁵⁵

⁴⁹ Second Witness Statement of Prof Sir Peter Horby (Chair of NERVTAG) : pages 22-23, para 87 – Reference to 5th Annual Report ([Link](#))

⁵⁰ Fifth annual report of NERVTAG (Jan 2020 – June 2021) Page 13 Para 4.8 : NERVTAG limited involvement with PPE/IPC ([Link](#))

⁵¹ [INQ000381168](#)

⁵² Letter from HSE (17 June 2021) confirming “HSE not involved in directing, influencing, or supporting PHE/DHSC policy and was not responsible for the guidance or approving thereof” ([Link](#))

⁵³ Email attaching draft ‘FAQ’ document for HCWs following the IPC step down from FFP3 to FRSM ([Link](#))

⁵⁴ Draft ‘FAQ’ document for HCWs following the IPC step down from FFP3 to FRSM - HSE comments in ‘Track Changes’ : ([Link](#))

⁵⁵ Letter to Ms Sarah Albon : HSE failure to enforce RIDDOR-reporting in the Health & Social Care sector. (Section 1.2) (20 Mar 2023) ([Link](#))

This was on the presumption that, if they were following Government IPC guidance, then they couldn't possibly have contracted the disease at their place of work even though that guidance was not fit for purpose and positively endangered health. It failed to address the risk of HCWs providing close-quarter care of infectious patients and the risk of working in environments where the air was a 'soup' of SARS-CoV-2 virions (often blamed on 'HCW-to-HCW transmission').

- This is the first time in the history of the HSE since its formation in 1974 that this powerful Regulatory and Enforcement agency actively encouraged duty-holders to breach their statutory duties and commit offences under health and safety legislation, not just once, but twice:
 - (i) In respect of the use of FRSMs to 'protect' against inhalation of pathogenic virus; and
 - (ii) In respect of the duty to report employee illness and death where the cause of infection could reasonably be attributed to occupational exposure

2.11. The 'root cause'

Health and Safety Practitioners, in their training for accident investigation, are always taught to follow HSE's recommended methodology. This is set out in a helpful guidance document.⁵⁶ It stresses the importance of not just looking at the superficial causes of an incident but methodically drilling down to establish "the root cause". Unless this is properly identified, any remedial measures taken to resolve the superficial causes are likely to be ineffective in preventing a recurrence unless the issues at the root cause are properly addressed.

The HSE guidance is very clear about where these "root causes" usually lie – as the following extracts reveal:

- Definition: **Root cause:** an initiating event or failing from which all other causes or failings spring. Root causes are generally management, planning or organisational failings.
- "The root causes of adverse events are almost inevitably management, organisational or planning failures".
- "The root causes of almost all adverse events are failings at managerial level"

Despite the sheer scale of this UK-wide incident, the broad scope of causative factors and, not least, the difficulties involved in extracting relevant information from Government Departments and Agencies, the HSE methodology holds good. It is possible to suggest a plausible 'root cause' for the events of 22-23 December which resulted in hundreds of thousands of healthcare workers being left without effective respiratory protection during the height of the second wave when, ironically, there were enough respirators in stock which could have been made available to them.

At the start of this "second wave" investigation, it appeared to begin with the IPC Cell meeting on the 22nd December with the PHE proposal to extend the use of FFP3 respirators, together with all the arguments and conflicting evidence for and against. However, piecing all the evidence together, of the hundred or so emails eventually obtained, just 3 short emails revealed the likely 'root cause' to have stemmed from the day before:

Monday: 21 December 2020 20:22

From: Senior Private Secretary to the Secretary of State (Matt Hancock)

To: 'PPE briefing', Michael Dynan-Oakley and 2 others (redacted)

Cc: Jonathan Marron and Special Advisers

Subject: Urgent: Advice on FFP3 masks

The SoS has requested some urgent advice on supplies of FFP3 masks. In particular how many we currently have available, and how supply levels are in relation to our current demand.

Tuesday: 22 December 2020 07:35

From: Jonathan Marron

To: DHSC (redacted)

Subject: RE: Urgent: Advice on FFP3 masks

⁵⁶ "Investigating Accidents and Incidents – A workbook for employers, unions, safety representatives and safety professionals (HSG245)" ([Link](#))

When you go back can you see if the PO (Private Office) know why he is asking

Tuesday: 22 December 2020 09:26

From: DHSC (redacted)

To: Jonathan Marron

Subject: RE: Urgent: Advice on FFP3 masks

PO have advised that SoS' exact request was –

"How many FFP3 masks do we have? Chris Whitty fears we may have to make them standard of care".

The one single word which may be attributed as the “root cause” is “**fears**”.

As a rule, if you ‘fear’ something, then you do not want it to happen. If you are the Chief Medical Officer in the land, advising the Secretary of State on everything to do with healthcare and medical matters during a national emergency, then those fears and concerns will be persuasive on everything which ensues and will most likely cascade down the entire system. The email chains cascade Professor Chris Whitty’s “fears” down through DHSC and the extreme urgency if conveyed through to the PHE and the IPC Cell.

If we cycle back to section [2.2](#) above, we recall the detailed email from Dr Brown and the PHE IPC Team to the senior manager (*possibly Prof Susan Hopkins, though redactions make this uncertain*). The email started “[we have reached a new decision point for IPC/PPE, based on conversations we had on Monday](#)”.

It was quite right and proper for there to be close communication between the Chief Medical Officer and PHE’s COVID-19 Incident Director and other senior members of PHE. Whether it was Professor Hopkins or another manager who had the conversations referred to above, it was absolutely right and proper for the DHSC and the CMO to be informed about an impending move by PHE towards recommending wider use of FFP3s. So the CMO Professor Whitty will have undoubtedly become aware of this and then shared his fears and concerns to the Secretary of State.

Why Professor Whitty should have “feared” making them standard of care is something only he can answer. On the face of it, the prospect of doctors, nurses and indeed all healthcare workers at the COVID front line at last being able to access effective respiratory protection should have been great news which he would have welcomed, celebrated and applauded as a great success, not feared. Indeed he, himself was serving at the front line in addition to his CMO duties.

Given the information obtained during this research, five possible reasons for these ‘fears’ emerge. Put bluntly, these could be categorised as follows:

- 1) “What would other professions think?” i.e. the impossibility of providing FFP3 to all other groups of workers;
- 2) “FFP3s are not a lot of fun to wear” i.e. discomfort, facial irritation;
- 3) “We could be accused of having got it wrong in the past” i.e. denying ‘airborne transmission’ (hence failing to provide ‘airborne precautions’ (RPE);
- 4) COVID-19 has got much worse through its increased transmissibility; and
- 5) Demand for FFP3s will greatly increase, together with logistical supply and fit-test issues

Considering these in more detail:

- 1) Concerns were aired within the IPC Cell along the lines that if RPE were to be provided for frontline HCWs then this may have to be extended to other sectors because they would become aware of the risk from airborne virus. However, sometimes Governments have to make bold decisions and prioritise resources for the greater good. That is the essence of good leadership.

Frontline healthcare workers were clearly facing the highest exposures, working up to 12 hour shifts in the red/high risk pathway. They were at the very sharp end of the COVID front line and the most deserving of the best protection that was available – and, as we have discussed, it **was** available.

If concerns about ‘how other groups of workers might feel about it’ contributed to the decision to sacrifice healthcare workers then history may judge the decision-makers harshly.

- 2) Some insight into Professor Whitty’s own views on the wearing of FFP3s can be found in comments made at the lectern in a later N°. 10 briefing (4 Jan 2022) ⁵⁷. He was asked by the Prime Minister to respond to a question regarding the fact that healthcare workers were not being provided with FFP3 respirators:

The Prime Minister asked me to comment about FFP3 ... There is a technical question for which there is a debate about what are the situations where it is useful and which are the situations where it isn’t. Nobody wishes to wear an FFP3 if they don’t need it – they’re not much fun to work in. But on the other hand they must have them when they are in the right place and that is a technical discussion and there are several different views on it.”

The telling comment here is “**not much fun to work in**”. However, that is a personal opinion which should not affect Government policy. Workers in various industries the length and breadth of the country have to wear RPE (including FFP3) in circumstances where they would otherwise be exposed to significant danger. There will have been thousands of HCWs who would have gladly put up with FFP3 being “not much fun” in order to protect themselves from a potentially crippling and lethal disease, but were denied that option as a result of Government IPC dictats. From a comfort point of view, it would have been better if, as discussed in section [2.7](#) above, the Government had followed the Southampton example and provided powered respirators as an alternative for sessional use which are far more comfortable and have several advantages over FFP3 – as explained in this short report. ⁵⁸

Any senior official advising the Secretary of State needs to be mindful that their views and feelings about a matter may directly or indirectly affect national policy. It is important that they stay within the limits of their technical knowledge and competency. During his oral evidence to Professor Whitty made a point of emphasizing: “**the areas of PPE, it’s a highly specialist area; it’s not one that I get involved in under ordinary circumstances, nor is it my technical expertise.**” On being questioned about responsibility for decisions about PPE, he replied “**ultimately, the responsibility for decisions was taken by the IPC Cell ... and technical advice to them came through Public Health England**”. The supreme irony of this statement will not be lost on readers, given the way that Dr Colin Brown, Dr Renu Bindra and their IPC expert colleagues in PHE were shut down by the remainder of the IPC Cell, not just on 22-23 December 2020 but time and time again – as will be evidenced in the following sections of this report.

Professor Susan Hopkins articulated her opinions about FFP3s during her oral evidence to the Inquiry when trying (unsuccessfully it seems) to persuade Lady Hallett and Counsel to the Inquiry that there was not a lot of difference between FRSMs and FFP3s and that wearing FFP3s could be harmful: “**...actually, there were harms from wearing FFP3s as well: there was blistering on faces, and there were significant harms.**” ⁵⁹

This was at a time when professional associations and unions representing over a million healthcare workers, working across all sectors (e.g. hospitals, care homes, ambulances, homes etc) were actively lobbying to get effective respiratory protection for their members who bravely went to work, fearing not only for their own lives, but also that of their families. As will be discussed in section [9](#), healthcare workers were being admitted to hospital with COVID-19 at three times the rate of the public, and their family members at twice the rate. This would have been apparent to healthcare workers themselves, seeing colleagues being returned to their hospitals as patients and dying before their eyes. It was obvious to many that the deficiencies in RPE were causative in these tragedies. This was related by CATA member, Dr Gillian Higgins, in her statement to the Inquiry:

⁵⁷ N°. 10 briefing : Professor Sir Chris Whitty responding to question regarding the availability of FFP3 respirators for healthcare workers (4 Jan 2022) ([Video Link](#))

⁵⁸ Respiratory protection of healthcare workers in future pandemics to mitigate airborne transmission – David Osborn (12 Nov 2024) ([Link](#))

⁵⁹ Transcript: Module 3, UK Covid-19 Inquiry : Evidence of Professor Susan Hopkins (18 September 2024) pdf page 22, Transcript page 86, L.17

“My colleagues also experienced seeing and having to treat our own team-mates on ICU and High Dependency Units (“HDU”), many of whom sadly died, including two members of my team. The two members of my team that passed away were porters, whose role during the pandemic was to transport patients up and down from A&E to ICU in the lifts. They had an intense exposure to COVID positive patients, in cramped and poorly ventilated spaces”.

Against this backdrop, individuals such as Professors Whitty and Hopkins presumed too much to impose their own personal opinions about comfort and minor dermatological side effects (*‘minor’ in comparison with severe illness and death*) on the healthcare workforce. Neither should they have allowed their personal preferences to influence national policy and suppress initiatives such as that being advocated by Dr Colin Brown and his IPC colleagues. Again, history may judge such decision-makers harshly.

Professor Hopkins later added ***“Personally, I think that we should have an enabling situation with FFP3s, and I call it enabling, rather than mandating, and that means that people are able to judge their own personal level of risk better, that they are able to get fit tested regularly, that there's a range of masks available to fit them.”***⁶⁰

Professor Whitty also added ***“Personally I would give people choice within reason”.***

It is a shame that, since the professors held that view, they couldn’t express it and use their influence back in December 2020 when HCWs were being ordered, on pain of disciplinary, to remove any self-purchased RPE as it ‘contravened Government guidance’ and their equipment was ruthlessly being confiscated. That said, health and safety legislation does not leave decisions about whether or not to wear PPE to employees. It is for employers to decide via risk assessment and then, if PPE is required, employees are legally required to wear it. However, notwithstanding the legalities, Professor Hopkins’ views may have been a pragmatic solution under the circumstances. This would, of course, have required employees to be given honest and truthful information about the airborne route of transmission so they could make an informed choice about the efficacy of RPE (which protects against inhalation of infectious viruses) vs FRSM (which doesn’t) as opposed to the messaging about ‘droplet transmission’ which had been introduced into IPC guidance back in March 2020.

- 3) Recognition of airborne transmission by providing ‘airborne precautions’ may indeed have been perceived by healthcare workers as “having got it wrong in the first wave” – because, yes indeed, they had got it wrong. Yet again, history may judge harshly anyone who refused to ‘change track’ because of a fear of personal or institutional consequences.

Some useful insight can be gleaned from by reference to Inquiry document INQ000073231.⁶¹

Unfortunately no further details can be provided for the remainder of this section as the information is drawn from emails between Government officials which the Inquiry Chair has not yet authorised to be released into the public domain

Relevant document INQ numbers are retained in the footnotes for future reference as and when they are published

⁶² ⁶³

⁶⁰ Transcript: Module 3, UK Covid-19 Inquiry : Evidence of Professor Susan Hopkins (18 September 2024) pdf page 24, Transcript page 95, L.8

⁶¹ INQ000073231

⁶² Maria van Kerkove (World Health Organisation, Infectious Disease Epidemiologist and Covid-19 Technical Lead) discussing airborne transmission (miscellaneous dates 2020) ([Link](#))

⁶³ World Health Organisation – social media post relating to the transmission of COVID-19 (28 March 2020) ([Link](#))

3. The second challenge – ‘Deja Vu’ for Public Health England

Following their unsuccessful attempt in December 2020 to persuade the IPC Cell to adopt a precautionary approach and extend the use of RPE more widely, the scientists in Public Health England no doubt watched with dismay as COVID-19 infections ran rampant throughout the healthcare sector (with around 50,000 hospital staff being off work with COVID-19 in January 2021) and the HCW death toll rising inexorably as the ‘Kent/Alpha’ variant wrought its havoc and brought the health service to its knees.

One can only imagine the emotional turmoil and anguish that good people like Dr Colin Brown must have been going through in the knowledge that the unfolding tragedy could have been so very different if the IPC Cell had accepted airborne transmission and extended the use of RPE as he and colleagues in PHE had proposed. The dogmatic stance taken by the Cell must have been particularly frustrating since the nation now had adequate stocks of FFP3 to achieve this – at least sufficient to equip frontline staff in ‘red’/high-risk pathways such as wards with cohorted infectious patients.

3.1. The gathering storm

In January 2021 the Government came under increasing pressure from the Healthcare sector about the inadequate respiratory protection they were being given. The death toll and sickness levels amongst HCWs was plain for all in Government to see.

NHS Health Trusts and Health Boards had received what amounted to a ‘3-line whip’ from Government in the form of the “Lines for Leaders” document prepared by [[Sue Tranka](#)] and [[Prof Mark Wilcox](#)] and others (as per section 2.9 above). This message was cascading down through these organisations, enforced with a firm hand. The mantra was that “Government policy must be obeyed at all costs”. Those doctors and nurses who knew that surgical masks would not protect them and elected to purchase their own respirators (or had them supplied by charities such as MedSupplyDrive) were ordered to remove them on pain of disciplinary proceedings. It seems that some particularly nasty healthcare employers actually confiscated the respirators (never to be returned) and resorted to deplorable tactics such as telling anyone who refused to surrender their respirator and subsequently died, their family would not receive the £60,000 ‘death-in-service’ compensation.⁶⁴

A groundswell of dissatisfaction was steadily gathering momentum as can be seen by these examples in January 2021:

- the AGP Alliance wrote to Secretary of State Matt Hancock requesting his personal intervention to ensure that HCWs are provided with the RPE that they needed;⁶⁵
- FreshAir-NHS, AGP Alliance and over 1,600 signatories sent an open letter to Prime Minister Boris Johnson and Ministers in all 4 nations requesting improved ventilation and enhanced standards of respiratory protection;⁶⁶
- AGP Alliance issued an emergency call to Secretary of State Matt Hancock : “Stop praising us and start protecting us!”.⁶⁷

3.2. Government attempt to quell the storm : SAGE paper ‘S1169 masks for healthcare workers’

Clearly such impassioned and publicly vocalised representations by the ‘Healthcare Heroes’ who had been fighting the frontline war against the virus and for whom the public had been clapping at their doorsteps on Thursday nights could not go unanswered. Action had to be taken. Whether the action which ensued was out of genuine concern for their health, safety and welfare or for political expedience or a mixture of both is for others to decide.

⁶⁴ Witness Statement of Ms Gillian Higgins to the UK Covid-19 Inquiry : INQ000421873 (3 Jul 2024) ([Link](#))

⁶⁵ AGP Alliance letter to Rt Hon Matt Hancock MP : Request intervention to ensure HCWs have appropriate PPE (19 Jan 2021) ([Link](#))

⁶⁶ FreshAir-NHS, AGP Alliance and others write open letter to Prime Minister and Ministers of 4-Nations (3 Jan 2021) ([Link](#))

⁶⁷ AGP Alliance press statement calling on Matt Hancock to provide all HCWs with access to FFP3 respirators (20 Jan 2021) ([Link](#))

The Scientific Advisory Group for Emergencies (SAGE) commissioned the preparation of a paper entitled “**Masks for Healthcare Workers to mitigate airborne transmission of SARS-CoV-2**”. The paper was written by ⁶⁸ ⁶⁹ and was published on 23 April 2021, given the reference number S1169 ⁷⁰.

It is important to note the presence of the term “**airborne transmission**” in the title. This was a clear, unambiguous recognition that SAGE accepted that airborne transmission was an important factor in the spread of the disease. Logically this ought to have resulted in an immediate acceptance that “airborne precautions” were required in line (a) with the pre-pandemic IPC Manual and (b) Health and Safety legislation. The IPC Cell should have immediately changed the guidance to enable the issue of FFP3 (or equivalent) respirators to all HCWs caring for COVID-19 patients. It should not have needed the procrastination of drawing up a paper to achieve this while HCWs were continuing to fall ill and die.

CATA’s health and safety advisor conveyed his dismay at the inadequacy of this paper, both to the Chief Executive of HSE ⁷¹ and in his report to the Commons Health and Social Care Select Committee ⁷². The following extract gives an impression of the withering critique of the paper:

“I am not just disappointed, but utterly dismayed, at the way the fundamental principles which underpin good health and safety practice in this country (the ‘hierarchy of risk controls’, ‘precautionary principle’ etc) have been so contorted and wilfully misused in an attempt to dismiss the contribution that effective respiratory protection (such as FFP3 respirators, reusable half/full-face respirators or powered respirators) can play in the close-quarter care of infected patients.”

3.3. Public Health England review of the SAGE paper S1169

Unfortunately no further details can be provided for the remainder of section 3.3 as the information is drawn from documents which the Inquiry Chair has not yet authorised to be released into the public domain

Relevant document INQ numbers are retained in the footnotes for future reference as and when they are published

⁷³ ⁷⁴

..... This was communicated by Ms Jackie McIntyre (a strong proponent of surgical masks for ‘protection’ of HCWs who is on record as actively advising doctors against the use of respirators ⁷⁵ ⁷⁶

⁶⁸ [INQ000398159](#)

⁶⁹ [INQ000398160](#)

⁷⁰ SAGE paper S1169 ‘Masks for healthcare workers to mitigate airborne transmission of SARS-CoV-2’ – 23 April 2021 ([Link](#))

⁷¹ Letter to Ms Sarah Albon, CEO, HSE – 16 May 2021 ([Link](#))

⁷² Written Evidence Submitted to the Health & Social Care Select Committee – [Link](#) (Section 10: “A response to SAGE report S1169”)

⁷³ [INQ000348395](#)

⁷⁴ [INQ000348396](#)

⁷⁵ ‘Pulse Today’ (Journal for GPs) : Report of Webinar 13 Jan 2022 : Ms Jackie McIntyre reportedly advised GPs not to routinely wear respirators as “surgical face masks give ‘very good protection’ ”. ([Link](#))

⁷⁶ [INQ000348405](#)

3.4. The competence of the IPC Cell in the context of health & safety legislation and practice

3.4.1. The meaning of “competence” and relevance to the IPC Cell

The sudden introduction of the term “hierarchy of controls”, well over a year into the pandemic, is worthy of some consideration at this point. It is not considered necessary to explain the principles underpinning the hierarchy here as readers can find an explanation in CATA’s witness statement for module 1.⁷⁷

The term is well familiar to the Inquiry Chair – as evidenced by her direct questioning of Ms Laura Imrie which demonstrated her ladyship’s ‘common-sense’ approach towards application of the hierarchy, as opposed to the dubious application of the hierarchy by the IPC Cell. This seemed intended to discourage the use of FFP3, justify the Cell’s position restricting respirator use and effectively ‘pass the buck’ onto NHS Health Trusts, Boards and other employers to determine for themselves when FFP3 should be worn as opposed to FRSM or indeed no mask at all. In so doing the IPC Cell evidenced that they failed to properly understand how to apply the hierarchy, particularly in the context of close-quarter care of patients who were suspected or confirmed to have COVID-19. This is discussed in section [3.4.3](#) below.

The members of the IPC Cell were, through the issue of their IPC Guidance, giving advice in matters of occupational health and safety. Whether they knew it or not (and they probably didn’t) there are statutory laws relating to the giving of health and safety advice which, if breached, render offenders liable to prosecution under section 36 of the Health and Safety at Work etc Act 1974

Meanwhile the Inquiry is invited to consider the question of competence of the IPC Cell members. This may help inform her ladyship’s recommendations regarding the governance of such groups when future pandemics occur.

First of all, we should consider what is meant by the words “competent” and “incompetent”. A suitable definition of “competence” is to be found at Regulation 7(5) of the Management of Health and Safety at Work Regulations 1999⁷⁸ i.e. **“A person shall be regarded as competent ... where he⁷⁹ has sufficient training and experience or knowledge and other qualities...”**. Any conclusions drawn as to the competence or incompetence of IPC Cell members need to be considered against these criteria – at least as regards occupational health and safety. It must be stressed that these considerations have no bearing on their competency in other professional fields such as infection prevention and control, anti-microbial resistance, workplace hygiene and cleanliness or other activities of this nature. Neither is there any intention to cause offence to, nor impugn any person. This section of the report is solely concerned with objectively setting out evidenced facts in order to allow the Inquiry Chair to formulate conclusions and make such recommendations as she feels appropriate.

The “hierarchy of controls” is one of the most basic, fundamental principles involved in occupational health and safety management. It is taught alongside “risk assessment” at the most rudimentary level of H&S courses. It is included in all courses for health and safety managers, line-managers and supervisors as well as introductory courses for shop-floor workers. It therefore follows that if a person has no knowledge of the “hierarchy of controls” then they are de-facto incompetent in matters of occupational health and safety and certainly unfit to issue guidance which materially impacts on the health and safety of the workforce, particularly one as large as the NHS and at a time of increased risk through pandemic.

3.4.2. A meeting with Mr Duncan Burton (DCMO, NHS-England) and Dr Lisa Ritchie (IPC Lead, NHS-E)

On 25 August 2022, at a meeting took place between two well-respected healthcare professionals (HCPs)

- Dr Clare Rayner; Consultant Occupational Health Physician, WHO Advisor

⁷⁷ INQ000174768 COVID Airborne Transmission Alliance : Witness Statement, module 1 – Hierarchy of Controls @ sections 19-32. ([Link](#))

⁷⁸ The Management of Health and Safety at Work Regulations 1999 : Regulation 7 ([Link](#))

⁷⁹ Where legislation refers to the male gender it equally includes females : Interpretation Act 1978, section 6

being interviewed in this video⁸² on the subject of PPE for healthcare workers caring for patients during a pandemic or major disease outbreak. He explains that "*PPE is their last (and only) line of defence against exposure to the pathogen*".

As discussed above, the IPC Guidance issued on 1 June 2021 read that respirators were to be used "***if an unacceptable risk of transmission remains following rigorous application of the hierarchy of controls***". At first sight this may seem reasonable guidance. However, it is not. The majority of interactions with infectious patients are when doctors, nurses, midwives, paramedics (etc) are providing care to the infectious patient at very close quarters where the two persons' breathing zones intermingle, resulting in the HCW inhaling virus from the patient's exhalations.

The key point here is that, in all these scenarios, not one of the control philosophies set out at (i) to (iv) above is a workable solution, so the only effective risk control measure is the provision of Personal Protective Equipment (PPE in this situation). The only potential solution for bedside care would be the provision of Local Extraction Ventilation (LEV) around the bedhead, though even then PPE would be advisable as backup where highly pathogenic microbes are involved. This would not, of course, be a solution for paramedics working in ambulances or other healthcare workers providing close-quarter care in community settings, where PPE is their only practical means of defence against infection.

If the skill-set within the IPC Cell had included at least one person with proven expertise in occupational health & safety, occupational hygiene or occupational medicine, they would undoubtedly have realised this important limitation of the hierarchy in the context of close-contact care. They could then have proactively mandated that PPE must be provided.

Whilst accepting that the first few months of the pandemic must have been extremely frenetic and stressful for senior managers (as it was for everyone else), their periodic governance reviews of the Cell arrangements, terms of reference etc provided ample opportunity to realise that additional skill-sets needed to be brought in to support the Cell. These were opportunities missed. It is these senior people who are ultimately responsible and accountable for the dangerous guidance which emerged from the Cell and the catastrophic consequences which it wrought across the health and social care sectors. After all, an incompetent person will not necessarily recognise their own incompetence especially when all those around them are lauding them as "Government Experts" or "Eminent physicians and scientists comprising the UK IPC Cell" as Ms Sarah Albon of HSE refers to them.⁸³

Nevertheless, most individuals in the IPC Cell (certainly at leadership level) will have been under their own duty to act within their scope of practice and recognise any limitations of their own competence. For instance, the Nursing and Midwifery Council Code reads "***The professional commitment to work within one's competence is a key underpinning principle of the Code which, given the significance of its impact on public protection, should be upheld at all times. In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register***". All regulators of healthcare professionals expect them to work within their scope of practice

The Inquiry Chair is invited to determine whether the individuals at senior management level within the various healthcare bodies which established the IPC Cell in NHS-England and later broadened it to become the 4-Nations IPC Cell, had a duty to ensure that its membership contained an appropriate mix of skills and professional backgrounds and whether or not this duty was, or was not, well met. This will be essential to any future determinations around Article 2 of the EU Convention on Human Rights and, indeed, civil litigation and/or criminal proceedings which may arise in the future.

⁸² Video of interview with Dr Brian Crook, Research Microbiologist, discusses PPE for highly pathogenic infectious diseases ([Link](#))

⁸³ Letter from Ms Sarah Albon, CEO, HSE : Response to allegation of offences by members of IPC Cell (14 March 2022) ([Link](#))

4. The third challenge: A defining moment in NHS History (but for all the wrong reasons)

4.1. 'Stakeholders' meet 'State' (3rd June 2021)

On 3rd June 2021, the Chief Nursing Officers, together with Dr Eleri Davies (Chair IPC Cell), Prof Wilcox, Prof Susan Hopkins and leading figures from DHSC (the 'state side') met with the representatives of over a million healthcare workers, led by Dr Barry Jones, Chair of the AGP Alliance (the 'stakeholder side'). This meeting came about following a letter to the Prime Minister, Boris Johnson⁸⁴, and to the 4-nations Chief Medical Officers⁸⁵ requesting an urgent review of IPC guidance. These letters emphasised the point that almost 1,000 health and care workers had lost their lives due to COVID-19 and the IPC policies were not properly addressing airborne transmission and that staff needed proper respiratory protection in order to reduce the risk of becoming infected while caring for infectious patients.

The 'stakeholder side' comprised senior clinicians, expert scientists, PPE experts, representatives of the BMA, RCN, RCM, the College of Paramedics, BAPEN, RCSLT, HCSA, DAUK etc⁸⁶ who all came together to present their concerns and solutions with one voice. Such a meeting was unique in the history of the NHS.

The stakeholders opened the meeting with a presentation outlining hard and fast scientific facts relating to airborne transmission, the need for RPE and the ineffectiveness of surgical masks. Most persuasive of all were the statistics presented (though these seemed to fall on deaf ears) such as the death rate amongst UK HCWs during the first wave having been 50% greater than in USA, despite the UK having only half the infection rate in the general population than in the US – a clear indication that the UK had got it wrong and, since nothing had changed in respect of HCW protection, was still getting it wrong.

4.2. Questionable conduct of the meeting chair, Mr Michael Dynan-Oakley

The teleconferenced meeting was chaired by Mr Michael Dynan-Oakley, Deputy Director, PPE Policy, DHSC (hereafter referred to as MDO) who mishandled the meeting from the start and whose conduct is highly questionable.

Shortly after the start of the meeting had begun, he asked people to treat the meeting as 'Chatham House' i.e. a secret meeting 'behind closed doors' (albeit by teleconference) without the names of anyone being disclosed or statements made being attributed to any individual person.

None of the 'stakeholder side' had any problem with their identities being attributed to what they had to say and indeed assumed that they would be reported in this way in the official record of the meeting (in whatever form that may eventually take). Although the Chatham House rule is ostensibly to enable 'free and unfettered' discussion, its introduction by the 'state side' in the context of this particular meeting reflects the secretive, covert nature of the IPC Cell and all those associated with it.

It is clear that MDO did not understand the rules relating to the Chatham House rule:

- First we should look at the rule itself: "***When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed***".
- Next we should look at the guidance underpinning the rule by reference to Chatham House's own official guidance. It specifies that the arrangements shall be **pre-agreed** between the parties before the meeting starts. **It had not been pre-agreed** for the meeting on 3 June 2021. This extract is taken from the Chatham House [website](#) as it existed at that time.

⁸⁴ Letter to Prime Minister, Boris Johnson, from the AGP Alliance, RCN and multiple other healthcare organisations – 18 February 2021 – [Link](#)

⁸⁵ Letter to the 4 Chief Medical Officers from the AGP Alliance, RCN and multiple other healthcare organisations – 12 March 2021 – [Link](#)

⁸⁶ See logos and signatories in the above letters for the full list of organisations being represented by the 'stakeholder side'

The Rule explained

Meetings do not have to take place at Chatham House, or be organized by Chatham House, to be held under the Rule.

Any group of individuals in any sector can use the Rule as a pre-agreed guide for running an event, particularly when issues of a sensitive nature are to be discussed.

There had been ample opportunity for the ‘state side’ to propose the use of the rule during the weeks and months before the meeting during which time many emails had been exchanged setting up the arrangements. There was no mention of it on the agenda and the meeting had already begun before it was even mentioned.

It is important that all parties at a meeting understand what is meant by the rule. MDO didn’t even refer to it as “the Chatham House Rule”, just “Chatham House” and blithely presumed that all the stakeholders present at the meeting even knew what he meant by “Chatham House” and what its implications were.

MDO assumed consent on the basis that he saw some ‘heads nodding’. These were ‘state side’ heads nodding, not stakeholders’. The ‘stakeholder side’ were completely blindsided by this turn of events. However, having waited almost 4 months for the State to convene this “urgent” meeting, with a large number of very senior state officials all having been assembled for the meeting and a defined timeframe for the meeting duration, there was no scope for argument or debate about this, so it had to be accepted.

- Following the Chair’s unexpected decision to apply Chatham House, Dr Barry Jones (lead for the ‘stakeholder side’) asked whether minutes would be taken. MDO confirmed that DHSC colleagues would take notes and that they “may want to share some top note minutes” afterwards. The Chatham House rule does not preclude the taking of notes or minutes and distributing these afterwards (redacting individuals’ identities). Minutes of such an important meeting should have been taken but, in practice, DHSC did not circulate any notes or minutes after the meeting and this represents a significant failure on the Chair’s part. His letter to the stakeholders after the meeting failed to give any form of account of the meeting and failed to properly address any of the questions that the stakeholders raised during the meeting.

4.3. A transcript is ‘leaked’

Fortunately, however, a Government employee, seemingly recognising the historic importance of the occasion, provided CATA and other Core Participants with a transcript of the meeting (accessible at the link below)⁸⁷, though respecting the anonymity requirements of Chatham House.

Given MDO’s failure to apply the rule correctly, for the purposes of this report the ‘Chatham House rule’ is considered to be ‘null and void’ and disappplied. Statements will be attributed to state officials who made them.

4.3.1. Aerosol/airborne transmission – The risk to staff caring for infectious patients

The ‘stakeholder side’ had pre-notified questions that they were looking to discuss and have answered. Clearly the most important one related the airborne/aerosol nature of COVID-19 transmission and the risk to HCWs providing close-quarter care of infectious patients, hence the need for respirators such as FFP3 to protect them. This was a question which cropped up in one shape or form three times during the meeting. Each time the Chair refused to allow to be answered. This is one example (see page 13 of transcript for full context):

A representative of the ‘stakeholder side’ asked a clear, direct question to Dr Eleri Davies (IPC Cell Chair):

- ***“I would just like to explore that a bit more short range (transmission). Is there an acceptance? Do the IPC Cell accept that there is a short range within a metre to a metre and a half risk of highly concentrated aerosol that will not be dealt with by ventilation, no matter how good it is?”***
- Mr Dynan-Oakley simply thanks the questioner and attempts to move on to the next question without giving Dr Davies any opportunity to reply.

⁸⁷ Transcript of meeting held under Chatham House Rule: AGP Alliance (later CATA) and other key healthcare stakeholders with the IPC Cell, DHSC, PHE, Chief Nursing Officers etc : 3 June 2021 : [Link](#)

- Dr Barry Jones (Lead for the ‘stakeholder side’) says “***Sorry, I’d like to hear the answer to my colleague’s question before I comment***”
- Mr Dynan-Oakley then overtly snubs Dr Jones’ request saying “***So I think what I’d prefer to do is to press on through the remaining questions...***”

At no point in the ensuing meeting did the ‘state side’ ever answer this reasonable and highly pertinent question, despite there being ample opportunity to do so. This illustrates the dismissive manner in which the ‘state side’ treated the ‘stakeholder side’ and the lack of respect shown by the Chair towards Dr Jones by repeatedly bypassing direct, highly relevant questions which were central to the purpose of the meeting.

4.3.2. Crucial evidence of airborne transmission was withheld from stakeholders

In their opening presentation, the ‘stakeholder side’ had made it quite clear that questions around airborne transmission were absolutely crucial to the safety of healthcare workers and that urgent acceptance of this was needed by the ‘state side’ in order to implement airborne precautions (FFP3).

Unfortunately no further details can be provided for the remainder of section 4.3.2 as the information is drawn from documents which the Inquiry Chair has not yet authorised to be released into the public domain

Relevant document INQ numbers are retained in the footnotes for future reference as and when they are published

88 89

4.3.3. Health and Safety Executive involvement with the IPC guidance – or not?

Another key point raised by the stakeholder group questioned the involvement of HSE in the development of the IPC guidance (transcript pages 11-13). Prof Mark Wilcox answered this by saying that the HSE had “very significant input” having contributed to a SAGE paper. He used this fact to infer HSE’s approval of the IPC guidance. Dr Barry Jones pushed back on this point and referred to the extensive communication the Alliance had had with HSE who absolutely denied having much involvement with the development of IPC guidance. He found it difficult to accept the statement that Prof Wilcox had made. Dr Eleri Davies, Chair of the IPC Cell then went on to assert that HSE was regularly consulted, they “considered” the IPC guidance and hadn’t raised any issues about it.

There is indeed very good reason to doubt the adequacy and credibility of these assurances. The SAGE paper in question was ‘Facemasks for health care workers to mitigate against airborne transmission of SARS-CoV-2’⁹⁰ mentioned in section 3.2 above, written by _____, having been commissioned by _____.

Professor Mark Wilcox was a logical choice to be the SAGE “lead” for this paper since he was:

- Chair of the **H**ospital **O**nset **C**COVID-19 **I**nfection Working Group (HOCl);
- a member of the **E**nvironmental and **M**odelling **G**roup (EMG);
- the National Clinical Director for IPC; and
- _____.

It is important to note that the EMG was co-chaired by Professor Andrew Curran, Chief Scientific Advisor, HSE (along with Prof Cath Noakes and Prof Harry Rutter).

To assess the likely contribution of these two groups (HOCl and EMG) to the paper we need to consider the role/‘Terms of Reference’ of these groups. Without a shadow of a doubt, IPC were ‘behind the steering wheel’ when it came to decisions about what PPE would be worn in healthcare settings and the circumstances in which it would be used.

⁸⁸ INQ000348394

⁸⁹ UK Health Security Agency : Composition of the Respiratory Evidence Panel (14 October 2021) ([Link](#))

⁹⁰ SAGE paper S1169 ‘Facemasks for healthcare workers to mitigate against airborne transmission of SARS-CoV-2’ – [Link](#)

Conversely, the EMG had quite different terms of reference which focused on modes of transmission, not PPE/RPE. Despite this, they consistently advocated the use of respirators such as FFP3 as the necessary protection for aerosol transmission.

Professor Curran's role as Chief Scientific Advisor and Director of the Science Division was very much focused on technical and scientific matters (including standards pertinent to RPE etc). However, it must be noted that it was **not** his role within HSE to make decisions on policy, compliance with legislation etc and it was certainly **not** his place to approve or disapprove of IPC policy for close quarter care of infectious patients. It is likely that he (or an HSE colleague) provided factual information relating to HSE's regulatory/enforcement activities (e.g. hospital inspections) and may have provided Prof Wilcox with some basic education on rudimentary concepts such as the 'hierarchy of controls' which were notably absent from in any IPC guidance published thus far. It is very doubtful that he would have expressed opinion as regards the use of surgical masks for close-contact care of infectious patients since, to do so would have meant straying way outside his role within HSE.

Any such decisions on policy or legislative compliance sit within what might be termed the "Core HSE" (i.e. the Directorates for Policy and Engagement, Regulation (field operations and enforcement) and the Chief Executive, Ms Sarah Albon. Their views, as communicated to the Alliance in writing by these senior decision-makers cast doubt on Prof Wilcox's and Dr Eleri Davies's version of events and their claims that HSE were closely involved with IPC guidance relying on surgical masks for HCW protection:

- 1) Letter from Sarah Albon⁹³ dated 29 April 2021 stating **"We are reviewing the recently published Scientific Advisory Group on Emergencies (SAGE) report S1169 Facemasks for healthcare workers and are considering if and how it may impact future IPC guidance"**. One has to ask why the HSE would need to be "reviewing" this paper if they, themselves, had played a really significant part in its preparation as they would have already known what it contained. The SAGE minutes for their meeting on 11 March 2021⁹⁴ make it clear that Prof Wilcox is the main 'owner' of this paper, answerable to SAGE.
- 2) Letter from Mr Martin McMahon⁹⁵, Acting Lead, Health and Social Care Services Unit, Engagement and Policy Division, HSE dated 17 June 2021 stating: **"HSE are not involved in the directing, influencing, or supporting PHE/DHSC PPE policy in relation to the COVID-19 IPC guidance for healthcare settings"** and **"HSE has been consulted and provided technical input on request to those responsible for the guidance. HSE is not however responsible for or has 'approved' the guidance"**.

These written statements cast doubt on the reliability and credibility of the Wilcox/Davies assertions about EMG/HSE's involvement with IPC. It was mischievous of Wilcox/Davies to suggest that Andrew Curran or anyone in EMG approved or supported the IPC guidance as a whole. In correspondence with our Alliance, Sarah Albon has reiterated time after time that HSE defer entirely to the Government experts on how to manage COVID-19 in the workplace. The extract below from her letter to Dr Barry Jones⁹⁶ makes this point very succinctly:

Coronavirus (COVID -19), like other infectious diseases, remains first and foremost a public health matter. Whilst, as you have noted, other experts may disagree with them, as we have made clear in previous correspondence, DHSC, working closely with UKHSA and the devolved administrations are the government experts in public health and infection control. They lead the Government response on how to manage COVID-19 and other respiratory infections both in the community and in the workplace.

The evidence provided by Prof Cath Noakes (co-chair of EMG) to the UK COVID-19 Inquiry shows that she would never ever have permitted any EMG support for 'droplet precautions' and the use of FRSMs.

⁹¹ [INQ000489982](#)

⁹² [INQ000349110](#)

⁹³ Letter from Sarah Albon (HSE CEO) concerning risks to healthcare workers, transmission evidence – 29 April 2021 – [Link](#)

⁹⁴ 83rd SAGE meeting on COVID-19, 11 March 2021 – [Link](#)

⁹⁵ Letter from Martin McMahon (HSE) concerning responsibilities for IPC Guidance – 17 June 2021 – [Link](#)

⁹⁶ Letter from Sarah Albon to Dr Barry Jones – 26 May 2022 ([Link](#))

4.3.4. The ‘silencing’ of Dr Brown and Public Health England colleagues (yet again!)

We now turn our attention to an extremely disturbing aspect of the arrangements for this meeting.

After the meeting on 3rd June 2021, Dr Colin Brown recorded his impressions of the stakeholders’ presentation in an email to colleagues in the PHE. This was obtained by a Freedom of Information request. Dr Brown noted that the stakeholders had made a compelling argument, which “echoed Public Health England’s optimal position for IPC Guidance” – a clear reference back to the IPC Cell meeting of 22 December 2020 when PHE had advocated for the extended use of FFP3 respirators as a precautionary measure. He also noted that the stakeholders wanted to work constructively with the IPC Cell going forward.

As mentioned above, one of the key questions pre-notified by the ‘stakeholder side’ to the ‘state side’, in advance of the meeting, related to the need for frontline healthcare workers to be provided with FFP3 or reusable respirators to protect them against COVID-19 whilst caring for infectious patients.

Initially the ‘state side’ intended that an expert from UK Health Security Agency (possibly Dr Colin Brown himself) would respond to that question. However, when the PHE’s “Position Statement” was received by Mr Dynan-Oakley and Dr Eleri Davies a few days earlier, it would have become clear that PHE would support (or at least not oppose) the stakeholder group’s contention that RPE should be available to all HCWs providing close care of infectious patients.

This would clearly be an embarrassment to the IPC Cell and State bodies who, for reasons best known to themselves, were staunchly opposed to the idea. So a last-minute ‘switch’ was made. The PHE representative was effectively ‘gagged’ and Dr Eleri Davies (IPC Cell Chair) was put in as a substitute to ‘toe the party line’, which she did, albeit rather unconvincingly. It is not known who actually made this decision but, on the face of it, it represents discreditable behaviour on someone’s part.

Finally, at the end of the meeting, Dame Ruth assured the stakeholder group that ***“we stand ready to work with you and to professionally debate and continue to work together to make more steps in the right direction”***. Sadly this was an empty promise. No attempt was ever made to engage with the stakeholder group to put these fine words into action.

To this very day, almost 5 years later, as evidenced by dismissive letters from Ministers and Chief Nursing Officers over the past year, every attempt by the Alliance to engage with Government/NHS or ideally the people it proclaims as ‘experts’ gets absolutely nowhere. Readers of this report may understandably interpret this as evidence that the Government ‘experts’ may actually not be as ‘expert’ as they would have us believe.

4.3.5. SARS-CoV-2 : A clever little virus which is airborne in homes but not airborne in hospitals

The stakeholder representing the RCN explained that she was frequently asked a question but which she struggled to answer. Government videos broadcast on television showed COVID moving like smoke in the air, encouraging people to open windows and increase ventilation.⁹⁷ RCN members had watched those videos, in which it is acknowledged as airborne in the home, but not reflected in a health and care setting.

Prof Wilcox gave a rather weak and unconvincing response, saying that his take on it was that it was just a visual depiction to try and get across the issue of virus being transmitted through the air, as opposed to specifically ‘small particle’ vs ‘large particle’. No one on the ‘stakeholder side’ of the meeting has yet been able to fathom out what he meant by this as it seems incongruous that the virus would be present in small ‘airborne’ particles in a domestic environment but in large ‘droplet’ particles in a hospital when they were all emitting from the respiratory tract of a human being. This not only gives valuable insight into the minds of those issuing IPC guidance but also demonstrates a lack of joined-up government in terms of consistency of messaging.

⁹⁷ Government video demonstrating how COVID-19 virus spreads through the air (18 Nov 2020) ([Link](#))

5. The fourth challenge – November 2021 (4 x Chief Nursing Officers)

5.1. CNOs instruct IPC Cell to consider greater RPE use and adopt a precautionary approach

On 24 November 2021, a new variant of SARS-CoV-2 was identified in South Africa. Two days later the WHO classified it as a ‘Variant of Concern’ and labelled it ‘**Omicron**’.⁹⁸ The evidence of this being a more dangerous variant was compelling. It raised concerns among health authorities worldwide. The key issues related to:

- its increased transmissibility, with a reproduction number ‘ R_0 ’ (commonly just called ‘ R ’) estimated at 1.9; and
- its potential for immune escape which could reduce the protection given by the vaccines which had been administered to the population, thus making people far more susceptible to severe disease.

On 26 November the 4 Nations’ Chief Nursing Officers met and discussed this worrying development.⁹⁹

It was noted that there were “huge pressures on all NHS staff, in particular Maternity Services”. In Northern Ireland alone there were 3,600 new cases a day. The CNOs discussed the health and safety of staff in the context of the new variant.

Discussions centred around the adequacy of the measures prescribed by the new IPC guidance, published just a few days earlier. This was the confusing edition of the guidance which allowed for respirators to be worn outside of AGPs, but only for diseases which were spread “**wholly**” by the airborne route – an undisguised attempt by the IPC Cell to try and exclude COVID-19 from RPE and restrict it to diseases such as TB. This would later backfire on them (as discussed below in section 8.4. The CNOs decided that staff would have to follow this guidance but it needed to be reviewed.

Although not formally recorded in the minutes, evidence in this email chain¹⁰⁰ suggests that the CNOs had taken note of the representations made by Dr Barry Jones and his colleagues from the AGP Alliance and its partner organisations at the large ‘stakeholder meeting’ which the CNOs had attended a few months earlier on 3 June 2021. It is pleasing to know that the CNOs had taken their representations seriously, whereas the DHSC and IPC Cell had dismissed them out of hand.

It also appears that the CNOs were considering a sensible option of providing FFP2s (instead of FRSMs) for frontline staff, leaving the FFP3s for AGPs.

Following the meeting, [**Sue Tranka**] spoke with [**Dr Eleri Davies**]¹⁰¹ to discuss this, then formally confirmed the CNOs’ collective requirements by email. The email was quite forthright and made their views very clear. The IPC Cell was instructed to review its guidance and consider the need for universal enhanced respiratory protection in healthcare settings i.e. provision of RPE such as FFP2 respirators as opposed to surgical masks. In doing so the Cell must take into account:

- (a) the recent WHO update on PPE for IPC; and
- (b) the evidence provided by the stakeholder group at the 3rd June meeting.

The IPC Cell were also instructed that if they did not support this proposition then they must provide reasons to justify why they were not adopting a precautionary approach. So far as can be determined from documents available, no reasons or justification were ever provided for the IPC Cell’s continuing refusal to follow a precautionary approach.

⁹⁸ World Health Organisation : Classification of Omicron (Variant B.1.1.529) as a ‘Variant of Concern’ (26 Nov 2021) ([Link](#))

⁹⁹ Chief Nursing Officers Forum Meeting (26 November 2021) ([Link](#))

¹⁰⁰ Email [**Sue Tranka**] to [**Eleri Davies**] : Commission UK IPC Cell to review respiratory protection of HCWs vs Omicron (26 Nov 2021) ([Link](#))

¹⁰¹ As per section 1.1 names formatted in this way were redacted in Freedom of Information documents, but a reasonable assumption has been made.

5.2. IPC Cell Reply: Decision to suppress the option offered by WHO allowing HCWs to use RPE

As can be seen in the email chain referenced above, by return, [Dr Davies] immediately replies to [Sue Tranka] promising a formal response from the Cell at a later time. In the meantime she forwards a copy of the latest WHO IPC guidance (1 October 2021)¹⁰².

However the version of WHO guidance forwarded by [Dr Davies] to [Sue Tranka] is worthy of some consideration at this point.¹⁰⁴ WHO had published this guidance 2 months before the emergence of Omicron. This revision showed a glimmer of change in WHO policy as it was beginning to open up the possibility of HCWs being provided with RPE in **all** COVID-care settings (i.e. not just limited to AGPs) when caring for confirmed/suspected infectious patients:

“Based on health workers values and preferences about having the highest perceived protection possible to prevent SARS-CoV-2 infection and where widely available, respirators can also be used instead of medical masks in all settings when providing care to COVID-19 patients in other settings (even settings where AGPs are not performed)”.

This raised HCW hopes that, at long last, they were going to be able to access proper RPE. However, these hopes were quickly dashed by the IPC Cell.

Unfortunately, WHO had headed this option with the text **“Conditional recommendation, very low certainty evidence”** which of course the IPC Cell immediately seized upon as an excuse for denying healthcare workers in the UK to take up the option of RPE if they felt it would protect them better (which of course it would).

Indeed that was most likely the reason for this **“conditional recommendation”** header being inserted in the first place i.e. to enable IPC groups to use it in the way that the UK Cell did. It is believed that there were links between the UK Cell and the WHO IPC team.

However, if we examine the actual paragraph covered by this **“conditional recommendation”** (in bold text above) it contains absolutely no parameter to which one could possibly ascribe any evidential certainty (high, medium, low or very low). One has to question what the evidence is that they are measuring and how is it being assessed in order to determine that it is “very low”?

The answer is that there is none. This is a complete ‘smoke screen’ by WHO. The only possible criterion present in that paragraph is whether respirators can be used instead of medical masks or can’t they? In other words “Is it safe to use them in place of medical masks or not?” i.e. “does a respirator afford better protection than a medical mask or worse?”.

¹⁰² World Health Organisation : IPC during health care when COVID-19 is suspected or confirmed (facilitates employee choice for RPE) ([Link](#))

¹⁰³ INQ000348422 :

¹⁰⁴ World Health Organisation : Recommendations on mask use by healthcare workers in light of the Omicron VoC (1 Oct 2021) ([Link](#))

¹⁰⁵ INQ000323836 :

¹⁰⁶ INQ000227346 :

If there was any question in the minds of the people in the WHO team that respirators were less safe / gave worse protection then they would have been negligent to have even made this suggestion in the first place.

It therefore follows that they must have considered that respirators would give equal or better protection than medical masks. In that case we come right back to the question, what evidence is it that is being measured and by what ‘yardstick’ was anyone able to assess it as “very low”. This lends weight to the supposition that this was indeed just a ‘hook’ (or ‘cop-out clause’) intended to enable IPC groups who wanted to suppress the personal freedom of choice being offered to health workers for their self-protection.

Some further evidence as to what was going on here can be found by reference to a later revision to the WHO guidance

1 October 2021	Conditional recommendation, very low certainty evidence Based on health workers values and preferences about having the highest perceived protection possible to prevent SARS-CoV-2 infection and where widely available, respirators can also be used instead of medical masks in all settings when providing care to COVID-19 patients in other settings (even settings where AGPs are not performed).
22 December 2021 ¹⁰⁷	<i>Respirators should be worn in the following situations:</i> <i>in care settings where ventilation is known to be poor* or cannot be assessed or the ventilation system is not properly maintained</i> <i>based on health workers’ values and preferences and on their perception of what offers the highest protection possible to prevent SARS-CoV-2 infection.</i> Note: this recommendation applies to any setting where care is provided to patients with suspected or confirmed COVID-19, including home care, long-term care facilities and community care settings. <i>(New conditional recommendation, based on very low certainty evidence)**</i> ** WHO provides this interim recommendation independent of the COVID-19 infection prevention and control Guidelines Development Group.

It is noted that the emphasis on “**New conditional recommendation, based on very low certainty evidence**” (which headed the October version) has been very much reduced and relegated to just a small footnote in the December version of the guidance. The WHO authors of this revised guidance also attribute the qualifier “**very low certainty evidence**” to their IPC-GDG group. It appears that the WHO authors of the guidance were seeking to distance themselves from that comment and produced it completely independently of the Guidelines Development Group.

This ‘downsizing’ and identifying the WHO IPC-Guidelines Development Group is significant as it suggests a growing dissatisfaction within WHO with the recommendations of that group persisting in their recommendation to continue the use of surgical masks as ‘protection’. In other words, a parallel situation which appeared to be developing between CNOs and CMOs with the IPC Cell persisting with the same recommendation – a dissatisfaction being voiced loudly by the Covid Airborne Transmission Alliance and partner organisations.

A leading and influential figure in the WHO IPC-Guidelines Development Group was Prof John Conly who was also the Chair of the WHO IPC Research and Development Expert Group for Covid-19. By this time, Prof Conly’s opinions against the significance of airborne transmission and against the use of respirators was being roundly criticised by a considerable number of highly respected experts in the field of aerosol science.¹⁰⁸ At a webinar hosted by the University of Calgary¹⁰⁹, the fundamental flaw underpinning WHO and UK IPC guidance was evident i.e. “**Droplet spread refers to larger droplet sizes (>10 microns) that generally fall within 1 metre**”.¹¹⁰

During the Q&A session Prof Conly was heard to say “**I think I’ve denied that airborne transmission can occur**”. A few minutes later he was heard to say “**I don’t think any one is denying airborne transmission**” (much to the surprise of other panellists and listeners around the world).

¹⁰⁷ World Health Organisation : Recommendations on mask use by healthcare workers in light of the Omicron VoC (22 Dec 2021) ([URL Link](#))

¹⁰⁸ CBC News article : Top Canadian WHO adviser under fire after downplaying airborne threat of COVID-19 (21 Apr 2021) ([URL Link](#))

¹⁰⁹ University of Calgary, Canada : Webinar concerning airborne transmission of Covid-19 (9 Apr 2021) Webinar recording at [URL Link](#)

¹¹⁰ Slide from presentation given by Prof John Conly at the University of Calgary Webinar (9 Apr 2021) ([URL Link](#))

It is noted that Scotland had been allowing ‘**personal PPE risk assessments**’ since February 2021. These were allowed for staff performing AGPs on a low-risk patient. HCWs were permitted to decide for themselves whether or not to wear a respirator. This is recorded in the ARHAI ‘rapid reviews of the evidence’:¹¹² i.e.

“in recognition of the anxiety felt by many HCWs with regards to PPE provision, Scottish guidance recommends that where staff have concerns about potential exposure to themselves, they may choose to wear an FFP3 respirator rather than an FRSM when performing an AGP on a low-risk pathway patient; this is a personal PPE risk assessment.”

So, with the general principle of “**personal PPE risk assessment to address staff anxiety**” having been well and truly established for eight months in Scotland, the Scottish contingent attending the IPC Cell may be open to criticism (and allegations of hypocrisy) for not recommending the option of ‘**Personal PPE Risk Assessment**’ and the individual choices afforded to Scottish HCWs for “low risk AGPs” to HCWs throughout the rest of the UK. At the same time they could have extended the scope from just “AGPs on low risk patients” to “**all** HCWs who may have anxiety providing general care (beyond AGPs) to ‘high risk pathway patients’”. This would have allowed HCWs to make individual choices and use FFP3 when and where they considered it necessary to do so for their own personal safety. That was the recommendation of WHO. Neither the IPC Cell nor the HSE had any right to deny that option to healthcare workers. That was overstepping their authority on legal, moral and ethical grounds. No doubt the fear of “healthcare colleagues feeling that they had been previously under-protected” would have still been in the mindset of Cell members as it had been in December 2020.

One would hope that Dr Davies, as Chair of the IPC Cell would have been paying close attention to important events at the World Health Organisation, monitoring any new guidance, initiatives, statements, statistics etc - particularly those which relate to healthcare worker safety and deaths due to COVID-19. Two such documents were produced a week before [Dr Davies] emailed [Sue Tranka] on 26 October 2021:

- 1) 20 October 2021: WHO published figures for health and care worker deaths during COVID-19 during the period Jan 2020 - May 2021.¹¹⁴ They estimated that between 80,000 - 180,000 died (a medium scenario of 115,500 deaths).
- 2) 21 October 2021: A Joint Statement is issued by Dr Tedros Adhanom Ghebreyesus (Director General, WHO) and 11 other leaders of international healthcare-related organisations.¹¹⁵
 - “The world cannot be complacent. More work is needed to minimise the risk of infection in the workplace”
 - “It is imperative that HCWs must get adequate protection to be able to do their jobs safely”
 - ***“We call on political leaders and policy makers to do all within their power to urgently make regulatory, policy and investment decisions that ensure the protection of the lives and wellbeing of health and care workers...”***

¹¹¹ INQ000398182 :

¹¹² ARHAI : IPC ‘Rapid Review’ : p.30 : option for HCWs (Scottish only) to elect to use RPE by Personal PPE Risk Assessment (5 Feb 2021) ([Link](#))

¹¹³ INQ000398185 :

¹¹⁴ World Health Organisation : Health and Care Worker Deaths during COVID-19 (during the period Jan 2020 – May 2021) (21 Oct 2021) ([Link](#))

¹¹⁵ Joint Statement on WHO’s Estimates of HCW Deaths due to COVID-19 (21 Oct 2021); News item ([Link](#)); The Statement: ([Link](#))

This was an important statement, direct from the heart of the World Health Organisation (in all senses of the word ‘heart’) to all healthcare leaders such as Health Ministers, Chief Medical Officers, **Chief Nursing Officers** etc. It is surprising that Dr Davies failed to also attach or mention this plea from WHO for health leaders to go further and do more to safeguard frontline HCWs – but of course this would have gone against the IPC Cell’s recent decisions not to go further and not to do more.

This statement was effectively a ‘call to arms’ from the Director-General of WHO asking countries to ‘go the extra mile’ in protection of healthcare workers, having regard to the carnage of thousands of HCW deaths worldwide in the first two waves. Had the CNOs seen this document it is possible (in fact probable) that they, and the CMOs, may have been minded to ‘put their foot down’ and support the UKHSA experts’ long-standing plea for a precautionary approach and the issue of respirators to all HCWs caring for suspect/confirmed infectious patients.

If Dr Davies had this latest WHO statement and withheld it from the CNOs then that is inexcusable.

If Dr Davies didn’t have this document then she and the IPC Cell were not doing their job properly by not adequately monitoring WHO closely enough at a critical point in the pandemic.

5.3. The curious position of HSE regarding the WHO guidance note

As mentioned above, the HSE emailed the IPC Cell _____

_____.
_____.

Whilst not seeking to excuse the position taken by the front line HSE Inspectors and scientists, their hands were tied. They were not given free rein to enforce in the way that they, as individuals, may have liked. They were under a ‘3-line whip’ that they must enforce in accordance with the IPC Cell’s guidance in healthcare and BEIS ¹¹⁶ guidance in other workplaces (as opposed to enforcing with the law, COSHH etc) as they would ordinarily do. **This was a truly extraordinary situation.** Evidence of this may be found in:

- (a) _____” ¹¹⁷

- (b) _____
_____ ¹¹⁸

_____.

¹¹⁶ BEIS : The Department for Business, Energy and Industrial Strategy

¹¹⁷ INQ000323836

¹¹⁸ INQ000269604

6. The fifth challenge - December 2021 (UKHSA and Chief Medical Officers)

6.1. Initial response by IPC Cell to the 'Omicron' variant

At the same time as the 4-Nations' Chief Nursing Officers were considering the implications of the Omicron variant, the 4-Nations' Chief Medical Officers and experts in UKHSA were also becoming concerned about the adequacy of IPC guidance continuing to rely heavily on FRSM as opposed to FFP2/3.

On 28th December 2021 a 'CAS Alert' had been issued by Prof Susan Hopkins (UKHSA) and Dame Ruth May/ Sir Stephen Powis (NHS-E) including their recommendation that "a precautionary approach is being advised"¹¹⁹. As we shall discuss, the IPC Cell did not agree that a precautionary approach was necessary and that their extant IPC Guidance which was largely based on FRSM would suffice, without any change to PPE recommendations.

A brief overview of these events was provided by Prof Susan Hopkins in her witness statement to the Inquiry:

1 Dec 2021	IPC Cell met to develop a consensus position statement. It was agreed that no changes to IPC Guidance/PPE were needed as no evidence of a change in the mode of transmission (<i>which they still believed to be 'droplets'</i>) ¹ . Prepared a statement to this effect (primarily for the 4xCNOs as discussed above).
3 Dec 2021	The 4 UK Chief Medical Officers discussed whether IPC guidance should be reviewed in relation to PPE/RPE and whether anything further could be done to protect staff
6 Dec 2021	The CMOs asked the IPC Cell to review and provide a 4-Nations consensus statement in time for their Senior Clinicians' Review meeting on 9 Dec.
8 Dec 2021	UKHSA attended a meeting of the IPC Cell and made the case for greater use of FFP3 respirators – just as they had done almost a year earlier in December 2020, advocating a more precautionary approach with the emergence of the Kent/Alpha variant. The Cell discussed this and the majority of members (<i>which heavily outnumbered UKHSA</i>) felt that such a move would be "disproportionate". In the end, UKHSA deferred to the wishes of the other Cell members and signed up to the consensus statement saying that the existing IPC Guidance was 'fit for purpose' (without changes to PPE).

¹ The Cell's reasoning for not changing PPE guidance was that there was no evidence of a change in the mode of transmission. As Dr Barry Jones (Chair, CATA) explained in his oral evidence to the Inquiry¹²⁰:

"Each time a new, more transmissible variant came along, the IPC Cell said: "We've reviewed the evidence and the virus hasn't changed its mode of transmission so we don't need to change protection"; It hadn't changed its mode of transmission of course, but as they'd got it wrong in the first place, that was the problem. That's the 'elephant in the room' again."

Dr Jones' reference to the 'elephant in the room' characterises the fact that the IPC Cell and those promoting the paradigm of "droplet transmission" were failing to understand the difference **between**:

- **an "aerosol"** i.e. a particle (solid or liquid) which remains suspended in air. In terms of disease transmission this includes microorganisms (e.g. viruses and bacteria) which emerge from the respiratory tract of an infected person contained in an aerosol of respiratory fluid. These aerosols (size approximately 100 microns) evaporate extremely fast (in a fraction of a second) and may dry out to form particles (still containing infectious virions) called 'droplet nuclei'. These are all considered to be 'aerosols' and a person inhaling them can be infected.

and

¹¹⁹ Central Alerting System (CAS) Alert: 28 Nov 2021 : COVID-19 Variant B.1.1.529 (Omicron) ([Link to page](#)) ([Link to CAS Alert](#))

¹²⁰ UK Covid-19 Inquiry : Transcript : Public Hearing (Day 4 – 12 Sep 2024) ([Link](#)) PDF page 11, transcript page 43 Line 6

- a “**droplet**” which, as the name suggests are particles of a fluid which are of a sufficient size to drop under gravity. The IPC Cell and other supporters of the “droplet paradigm” wrongly believed that anything over 5 microns would be a “droplet” and fall to ground within 1 to 2 metres (hence the COVID ‘2-metre rule’). The conceptual flaw that aerosols are less than 5-microns) became embedded into IPC guidance and manuals. This concept was augmented by the erroneous belief that the infective agent was carried in large droplet particles which in turn elicited the droplet mitigations advised in IPC guidance. Since aerosols >5 microns are to be found in large quantities and carry the bulk of infectious material, only aerosol mitigations are appropriate
i.e. the ‘elephant in the room’ because nobody in the IPC world could see what was so well known to aerobiologists for almost 100 years (Wells 1934)¹²¹ and reaffirmed by many distinguished scientists such as Dr Donald Milton and in evidence given by Prof Beggs at the Inquiry.¹²²

Dr Milton’s description and definitions of aerosols and ballistic droplets were based on sound, scientific principles established many years before the pandemic struck. He defined three categories of aerosol. These were:

- Respirable aerosols (less than 5 μ m[†]): will pass deep into the lungs i.e. the ‘alveoli’;
- Thoracic aerosols (5-15 μ m): will pass through to the thoracic region (chest); and
- Nasopharyngeal aerosols (15-100 μ m); will only reach to the nasopharyngeal region (nose/throat).

[†] μ m = microns = 1 thousandth of a millimetre

The IPC guidance, however, has been founded upon the false proposition that there were only two categories of respiratory emissions. These were:

- Aerosols (less than 5 μ m): will pass deep into the lungs i.e. the ‘alveoli’; and
- Droplets (everything larger than 5 μ m): will drop out of the air within approximately 2 metres but may impact on a mucosal surface such as the mouth, nose or eyes before reaching ground level.

This definition of ‘droplets’ has no basis in aerosol science whatsoever. Anything which readily drops out of the air in this way is described as behaving ‘ballistically’ - in other words its trajectory is largely influenced by gravity. The consensus amongst expert scientists (such as Milton and many others) is that droplets only properly exhibit ballistic behaviour when larger than 100 μ m.

The 100 micron threshold has the added credibility of being the size defined by the Health and Safety Executive as being the size below which particulates and aerosol fractions are deemed “inhalable” when setting exposure limits for hazardous substances for the COSHH regulations. This gives Dr Milton’s classification a compelling validity since it accords with UK health and safety legislation. The document which defines this is HSE publication “MDHS-14” (See link in footnote ¹²³)

As Dr Barry Jones (Chair, CATA) explained to the Inquiry during his oral evidence:

“This is not an academic distinction, it’s one of extremely important practical distinction and all pronouncements on ‘droplets’ by the IPC Cell are null and void as a result of Professor Beggs’ evidence”¹²⁴.

Dr Milton’s description and definitions of aerosols and ballistic droplets were all accepted by SAGE and expert scientists in HSE, the Environmental Modelling Group and the Respiratory Evidence Panel. However, the IPC Cell continued to ignore the science and their misunderstanding continues to pervade and undermine national IPC manuals to this day.

¹²¹ On Air-Borne Infection: Study II. Droplets and Droplet Nuclei : American Journal of Epidemiology (November 1934) ([Link](#))

¹²² A Rosetta Stone for Understanding Infectious Drops and Aerosols : Donald K Milton (24 July 2020) : ([Link](#))

¹²³ MDHS 14-4 : General methods for sampling and gravimetric analysis of respirable, thoracic and inhalable aerosols : **Methods for the Determination of Hazardous Substances** (June 2014) ([Link](#))

¹²⁴ Professor Clive Beggs PhD, PhD, FIMechE, FRSB : Bio-engineer and physiologist – Appointed by the Inquiry as an expert witness in respect of infectious disease transmission, aerosol dynamics and ventilation systems.

6.2. IPC Cell ‘on the defensive’ : Frictions arising between UKHSA, NHS-E and the IPC Cell

Documents disclosed by the Inquiry allow for a more detailed analysis of events and provide more insight into the mindset of some key members of the Cell, together with some rather prickly interactions between senior officials in UKHSA on one side and the NHS/IPC Cell on the other:

Unfortunately no further details can be provided for section 6.2 as the information is drawn from IPC Cell minutes

and other documents which the Inquiry Chair has not yet authorised to be released into the public domain

Relevant document INQ numbers are retained in the footnotes for future reference as and when they are published

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6.3. UKHSA prepares its challenge

Unfortunately no further details can be provided for section 6.3 as the information is drawn from IPC Cell minutes

and other documents which the Inquiry Chair has not yet authorised to be released into the public domain

Relevant document INQ numbers are retained in the footnotes for future reference as and when they are published

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6.4. IPC Cell meeting 8th December 2021 (deja vu for UKHSA colleagues)

Unfortunately very few details can be provided for section 6.4 as the information is drawn from IPC Cell minutes and other documents which the Inquiry Chair has not yet authorised to be released into the public domain

Relevant document INQ numbers are retained in the footnotes for future reference as and when they are published

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.....It is unclear where the evidence for this bold statement came from. The evidence available to CATA is that staff in those Trusts which used RPE (FFP3 and/or powered respirators) sustained lower infection rates. There was ample evidence of this at this time (for those who wished to listen) via research papers e.g. Ferris (Cambridge)¹³⁰ and Elkington (Southampton)¹³¹.

..... However, as Dr Ritchie later confirmed in her evidence under oath at the UK Covid-19 Inquiry, “the supply of PPE did not influence the IPC advice provided by the UK IPC Cell”¹³².

125 INQ000252535

126 INQ000398186

127 INQ000348429

128 INQ000348430

129 INQ000398184

¹³⁰ Efficacy of FFP3 respirators for prevention of SARS-CoV-2 infection in healthcare workers, Ferris et al; 16 Nov 2021 ([Link](#))

¹³¹ A Personal Respirator to Improve Protection for Healthcare Workers Treating COVID-19 (PeRSo), Elkington et al (10 June 2021) ([Link](#))

¹³² UK Covid-19 Inquiry, Transcript Day 5 (16 Sep 2024) pdf page 30, Transcript p. 118 L.10 and ([Link](#))

6.5. A more insightful account of the IPC Cell meeting by UKHSA representatives

Unfortunately only a few details can be provided for section 6.5 as the information is drawn from documents which the Inquiry Chair has not yet authorised to be released into the public domain
Relevant document INQ numbers are retained in the footnotes for future reference as and when they are published

¹³³ ¹³⁴ ¹³⁵ The final version of the Cell’s consensus statement was published on 17 December. ¹³⁶

¹³⁷

As a ‘finale’ to this confusing state of affairs, on 4th January 2022, at a “N°. 10 press conference” the Prime Minister invited Chris Whitty to respond to a question about the provision of FFP3s for healthcare workers. As can be seen in the video referenced below¹³⁸, as a part of his response he commented that “they’re not much fun to work in”.

There is no dispute about the wearing of FFP3 being “not a lot of fun”, but there are two key points to consider:

- When the consequence of not wearing the respirators is to suffer serious personal harm to one’s health, both in the short term and the long term, it should not be down to a group of people such as those in the IPC Cell to decide for them, and dictate to them whether they will be given or denied the required personal protection.

The notion that local health Trusts and Boards would be able to determine, through risk assessment and the application of the hierarchy of controls, whether RPE is needed or not is an absolute nonsense when providing close-quarter care of infectious patients. The only mitigation and protection against inhaling the virus is RPE.

- There are alternatives such as powered respirators which are far more suitable than tight-fitting FFP3 respirators which offer an excellent level of protection and were welcomed as a godsend by over 5,000 staff at Southampton University and other hospitals which adopted their use. As can be seen in the BBC report referenced below, ¹³⁹ these were particularly efficient and well liked by the staff there. Sadly healthcare leaders failed to listen to the representations of Professor Paul Elkington and colleagues at Southampton. Had they taken up an offer from Jaguar LandRover in April 2020 to mass produce thousands of these devices then virtually all healthcare workers could have been protected by this life-saving equipment by the time the deadly second wave struck in the winter.

¹³³ INQ000348428

¹³⁴ INQ000348423

¹³⁵ INQ000348423

¹³⁶ IPC Cell : Consensus statement in response to the Omicron variant of SARS-CoV-2 ([Link](#))

¹³⁷ INQ000398186

¹³⁸ Video of Professor Sir Chris Whitty at N°. 10 briefing discussing FFP3 respirators (4 Jan 2022) ([Link](#))

¹³⁹ BBC South News : ‘PerSo’ powered respirator developed and in use at Southampton University Hospital ([Link to video](#))

7. The sixth challenge – January 2022 (4 x Chief Nursing Officers)

Unfortunately few details can be provided for section 7 as the information is drawn from a set of IPC Cell minutes which the Inquiry Chair has not yet authorised to be released into the public domain

The relevant document number is retained in the footnotes for future reference as and when it is published

¹⁴⁰ **N.B.** When reading these minutes please be aware that reference to “HSE” is referring to the Irish Health Services Executive, **not** the UK Health and Safety Executive (a distinction which seemed to confuse ARHAI). The Health Services Executive is akin to the NHS in the UK although it also carries some public health responsibilities.

8. The seventh challenge - March 2022 (4 x Chief Nursing Officers)

8.1. Ms Tranka’s troublesome day (23 March 2022)

The 23rd March 2022 appears to have been a most troubling day for Ms Tranka (Chief Nursing Officer {CNO}–Wales). At 10am precisely, an email with a ‘briefing note’¹⁴¹ from Ms Miranda Morton of the Welsh Government’s Directorate for Health Policy Technical Advisory Cell (TAC)¹⁴² dropped into her Inbox. The previous day Ms Morton had attended a meeting with the HSE’s Chief Scientific Advisor (Prof Andrew Curran) and other expert scientists involved in the Health and Safety Executive’s ‘PROTECT’ National Core Study.

That briefing note effectively put Ms Tranka and Sir Frank Atherton (Chief Medical Officer – Wales) on notice that the Infection Prevention and Control (IPC) guidance was wrong to treat COVID-19 as a droplet-borne disease. Ms Morton categorically told them that aerosolised particles containing the virus would circumvent and penetrate ‘droplet PPE’ (surgical masks) and that there was an urgent need for IPC guidance to be changed to address this danger to staff.

To all intents and purposes Ms Tranka was told that the IPC guidance was not fit for purpose and that it exposed staff, whose health and safety she has a legal and moral duty to protect, to the danger of contracting a disease which seriously endangers their health, both in the short and long term.

Ms Tranka immediately emailed her concerns to the other CNOs¹⁴³. She appears to have been troubled at the thought that, if COVID-19 had been wrongly misinterpreted as a “droplet-borne” disease when in fact it was “aerosol-borne” (for which surgical masks are ineffective), then what might this mean as regards the consequences over the past two years in terms of avoidable HCW deaths and the innumerable cases of long-COVID which had shattered so many lives and livelihoods.

In her former role as Deputy CNO in NHS England, Ms Tranka was Dr Ritchie’s Line Manager and therefore had an overarching responsibility for the activities of the IPC Cell at the time when the IPC guidance was introduced which downgraded respiratory protection from FFP3 to FRSM. She would also have been aware of the influence that Prof Mark Wilcox would have had over Dr Ritchie and the IPC Cell¹⁴⁴.

Ms Morton’s concerns would most likely have reinforced the doubts about the adequacies of IPC guidance and the reliance on FRSMs that she and the other CNOs had shared just a few months earlier at the outset of the Omicron

¹⁴⁰ INQ000398188

¹⁴¹ Briefing Note from Ms Miranda Morton to Sue Tranka (CNO) and Frank Atherton (CMO) – 23 March 2022 ([Link](#))

¹⁴² The briefing note from Ms Morton and some emails referenced in this section of the report have been disclosed to CATA via a source who must remain anonymous. A certain amount of reprocessing has been applied in order to redact CNOs’ personal data. It should be noted that this source was **not** Ms Morton nor anyone in HSSG.

¹⁴³ Email: Sue Tranka to the other 3 Chief Nursing Officers ([Link](#))

¹⁴⁴ INQ000274148 : Witness Statement S Tranka: “The Head of IPC at NHS England, Dr Lisa Ritchie, reported directly to me.” ([Link](#))
Paragraph 18 “She was supported on a daily basis by medical advisor, Dr Mark Wilcox”.

wave when their own feeling was that protection should be via **Filtering Face Piece** respirators rather than FRSM (discussed in sections [5](#) and [7](#) above).

Upon receipt of Ms Tranka's email, Dame Ruth May (CNO England) seemed equally troubled, judging by the urgency expressed in her email, immediately forwarded it on to Professor Mark Wilcox, a senior figure at the IPC Cell meeting which was due to start at 10:30¹⁴⁵.

8.2. A token gesture to keep various 'factions' happy

In response to Ms Morton's briefing note, Ms Tranka asked the IPC authors to amend the online guidance [webpage](#) from:

"Main route of transmission : Droplet"
to **"Main routes of transmission are : droplet/fomite/aerosols"** (*emphasis added for clarity*).

The [webpage](#) in question was duly amended to read:

"Main route of transmission : Droplet / Airborne".

Ms Tranka justified this change on the basis that omitting these other routes of transmission may "**stir up much unease and criticisms with many factions**"¹⁴⁶. It is not known who these 'factions' were, but this should not have been a justification for correcting the National IPC Manual. The basis for making a change to the manual should be to ensure that it is scientifically correct and not providing misleading information which compromises HCW health and safety. It should not be done in just to keep certain groups of people happy. In any event the change of one single word into the depths of a large online document did not change anything. This is because "airborne precautions" (i.e. FFP3 or other respirators) were still not recommended alongside this now self-admitted "airborne disease".

Shortly after receipt of Dame Ruth May's email, Prof Wilcox spoke with Prof Andrew Curran (HSE Chief Scientific Advisor). He then replied to Dame Ruth via email¹⁴⁷.

{**Dr Eleri Davies (Chair, IPC Cell)**} replied to {**Ms Sue Tranka**} via email (23 March, 15:34), virtually copy/paste of the Wilcox email.¹⁴⁸

Prof Wilcox reported that "**HSE's position regarding the modes of transmission has not changed**" (note his emphatic underline of the word "not"). That is absolutely true, but that was not the point at issue here since Ms Morton was not suggesting that the mode of transmission had changed, simply that HCWs were at risk from a flawed IPC policy

We need to be absolutely clear on this point. HSE's position right back to the start of the pandemic had always been that COVID-19 was a disease caught by inhalation of infectious aerosols. As far back as April 2020, they issued guidance to their Inspectors that "**COVID-19 transmits when someone breathes in aerosolised droplets from an infectious person**".¹⁴⁹ They confirmed that people are "**at risk of airborne infection if they are within a metre of the person aerosolising the virus**" i.e. precisely the distance within which close-quarter care is given to infectious patients.

As every self-respecting HSE inspector and scientist knows only too well, the only way of properly protecting people in such an "**at risk**" situation against airborne, inhalable hazards is by use of RPE (Respiratory Protective Equipment) such as FFP3 respirators, not surgical masks. To their eternal shame, HSE failed to use their enforcement powers to ensure that HCWs were properly protected in this way and untold harm ensued as a result, but that is another story.

¹⁴⁵ Email: Dame Ruth May to Prof Mark Wilcox ([Link](#))

¹⁴⁶ Email: Ms Sue Tranka : 23 March 2022 at 16:13 ([Link](#))

¹⁴⁷ Email: Prof Mark Wilcox to Dame Ruth May following discussion with Prof Andrew Curran (HSE CSA): 23 Mar 2020 ([Link](#))

¹⁴⁸ Emails: Correspondence between CNO-Wales, Chair-IPC Cell, Member of Welsh Gov Technical Advisory Cell & others (23 Mar 2022) ([Link](#))

¹⁴⁹ INQ000269803 : HSE Guidance to Inspectors regarding Covid 19 transmission route – April 2020 ([Link](#))

The route of transmission was never the real point at issue here. The emails sent by Prof Wilcox and Dr Davies completely sidestepped the very valid, cogently expressed technical concerns about the inadequacy of “droplet PPE” (FRSMs) raised by Ms Morton which was getting Ms Tranka and the other CNOs so exercised.

The main thrust of Ms Morton's briefing note was to directly challenge the IPC Guidance in that it would not be fit for purpose if it continued to provide 'droplet PPE' (FRSM) against a disease which everyone agreed had an airborne component via aerosol transmission. She was not challenging the routes of transmission, so Prof Wilcox's assertion about HSE's own position on the matter was irrelevant and pointless. As one can see, Ms Morton is quite up front about this and, at points 3&4 fully accepts that transmission happens by ballistic droplets and aerosols (i.e. the "continuum" as Prof Wilcox describes it).

It would have been immediately clear to the CNOs that Ms Morton was challenging the principle which was firmly embedded in IPC guidance that surgical masks protect HCWs against the aerosolised fraction of this 'continuum' and was therefore endangering healthcare worker safety.

It should also be noted that Ms Morton acted in a highly professional and responsible manner drawing the inadequacy of PPE against SARS-CoV-2 to the attention of the CMO/CNO. It is unfortunate that she came up against Dr Davies and Prof Wilcox who dismissed her genuinely-held concerns, just as they had done to Dr Colin Brown (PHE) in Dec 2020 and experts from the stakeholder group (representing over a million healthcare workers) in June 2021 in order to perpetuate highly flawed and dangerous IPC Guidance.

It can be seen further down the same email chain¹⁵⁰ that Ms Morton came under fire from another person (*name redacted by Welsh Gov*) in the thread at the email sent at 23 March 11:04 who said:

“I really don’t understand where this is coming from and why it is cutting across the 4 Nations approach that we have adopted through National IPC Cell which is purposed to take an overview of all the evidence around transmission”;

“Is this supposed to be formal Technical Advisory Cell advice and, if so, has TAC considered either the cross Nation or operational implications?”.

It is pleasing to note that {**Ms Morton**} stood up for herself in the email above (timed at 13:50):

“I am sorry that I was not aware of the 4 Nations Cell, but it would be negligent of me not to raise with you that, to the best of our knowledge, and with a high level of confidence, droplet by the definition in the Welsh, and presumably Scottish, guidance is NOT the main route of transmission for COVID infection”;

“there seems to be a disconnect between the route of disease transmission in fact and in the guidance”.

The FoI request was submitted in July 2025 and, as at the time of publication of this report, HSE has failed to disclose the information upon which Ms Morton relied. The delay of 8 months represents a significant breach of the timescales set out in the Freedom of Information Act 2000. This is further discussed in section [12.4](#).

8.3. Questionable/misleading advice from Professor Mark Wilcox

No one will know for sure what passed between Prof Curran and Prof Wilcox during that conversation during the morning of 23/3/22, other than those two men. However, there appear to be three possibilities:

- 1) that Prof Curran endorsed the use of "droplet PPE" and agreed that FRSM gave suitable protection. If this was the case then surely Prof Wilcox would have relayed this fact verbatim to the CNOs? He did not; **or**

¹⁵⁰ Emails: Correspondence between CNO-Wales, Chair-IPC Cell, Member of Welsh Gov Technical Advisory Cell & others (23 Mar 2022) ([Link](#))

- 2) that Prof Curran agreed with Ms Morton that FRSMs were unsuitable for aerosolised virus and FFP3 would be required¹⁵¹. If this was the case then Prof Wilcox was remiss for withholding this information from the IPC Cell and the CNOs; **or**
- 3) Prof Wilcox never actually asked Prof Curran the question that was getting Tranka and May so exercised, which he had been specifically asked to resolve i.e. "**is FFP3 now needed for HCW protection or is it not?**". If this was the case then, once again, Prof Wilcox was remiss. As professors often say to their students "Answer the question you have been asked, not the question you wish had been asked".

If either (2) or (3) is the case then this leaves Prof Wilcox open to criticism. Indeed some might argue that he ought to be held to account for misconduct (i.e. misleading the CNOs on such an important matter that affected the health, safety and lives of hundreds of thousands of nursing staff across the UK).

In their respective emails, both Prof Wilcox and Dr Davies assured the CNOs that IPC Guidance was in line with WHO guidance. As can be seen by looking carefully at the WHO document, that was incorrect. The WHO recommendations issued three months earlier had cited two particular situations where respirators should be worn:

i) **"In care settings where ventilation is known to be poor".**

This applies to much of the NHS Estate and certainly applies in virtually all close-contact care settings where general room ventilation provides insufficient air movement to prevent the HCWs' breathing zone intermingling with that of the infectious patient; and

ii) **"Based on health workers' values and preferences and on their perception of what offers the highest protection possible to prevent SARS-CoV-2 infection".**

Considering this latter point in more detail. The representatives of over a million healthcare workers, led by Alliance Chair, Dr Barry Jones, had, at the state/stakeholder meeting on 3rd June 2021 (described in section 4 above), made it abundantly clear to the CNOs, IPC Cell etc exactly what their members' "**values and preferences**" were (i.e. *to avoid becoming infected through their work, especially while caring for infectious patients*). They had clearly and unambiguously set out their "perception"[†] of "**what offers the highest protection possible to prevent SARS-CoV-2 infection**" (i.e. *FFP3 and other RPE, not FRSMs*).

[†] Note: This was not just a "perception". The stakeholder presentation was underpinned with indisputable scientific evidence including references and published data.

8.4. IPC policy and guidance – An 'un-wholly' muddle!

In his email to Dame Ruth May and Duncan Burton, Prof Wilcox explains that he believes Ms Morton's communication was based on a 'misperception' on her part. He then goes on to comment "**Using 'wholly' in our recent guidance has not helped**". At least he admits the IPC Cell's folly in the use of this descriptor and the confusion it caused.

During the autumn of 2021, the IPC Cell engaged in a consultation exercise with stakeholders concerning a revision to the IPC guidance that was being drawn up. That said, some stakeholders were excluded from the consultation and not invited to participate. Despite representing tens of thousands of healthcare workers and despite having led the 'stakeholder side' of the meeting a few months earlier, the COVID Airborne Protection Alliance (a fore-runner of CATA) was not invited to participate in the consultation (perhaps considered a troublesome 'faction'?). Nevertheless the Alliance did hear about the exercise and made a number of constructive recommendations which, somewhat predictably, were ignored.

The revised guidance, when published on 24th November was a shambles – at least in respect of specifying PPE/RPE requirements. As regards general healthcare provision[†], the rule was that RPE was prescribed only when caring for patients with a disease that is "**wholly transmissible** by the airborne route".

[†] i.e. *excepting 'Aerosol Generating Procedures' and certain locations such as HDU etc*

¹⁵¹ Given that it was Prof Curran's own staff who researched the use of FRSMs vs FFP3s in 2008 (RR619) and found them to be useless against aerosolised viruses, it is difficult to see how he could have taken any other position without leaving himself open to criticism.

At that time it was believed that COVID-19 was spread by all three routes i.e. fomite, ballistic droplet and aerosol (though we now know that fomite transmission is very rare). So this was widely seen as an underhand method of excluding COVID-19 as a disease which requires respiratory protection for routine care of infectious patients. Since no-one seemed to know who this secretive group “the IPC Cell” were, let alone how to contact them, these protests were mostly directed at the HSE for failing to ensure that HCWs were properly protected.

What, if anything, happened behind the scenes between HSE and IPC is not known. However, the IPC Cell were obliged to remove the word “wholly” from the next iteration of guidance issued on 17th January 2022. They then came up with the idea of only recommending RPE for diseases which were “**predominantly airborne**” and this appeared in the next iteration dated 15 March 2022 (although judging by the various arguments about it, evident from the Tranka/May/Wilcox emails, was not actually published until the end of March).

This summary shows the bizarre transition from “wholly” through to “predominantly”:

Infection prevention and control for seasonal respiratory infections in health & care settings (including SARS2) for winter 2021 to 2022		
<i>24 Nov 2021</i>	<i>17 Jan 2022</i>	<i>15 Mar 2022</i>
‘A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when: • caring for patients with a suspected or confirmed infection spread wholly by the airborne route, such as tuberculosis (TB) (during the infectious period)	‘A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when: • caring for patients with a suspected or confirmed infection spread by the airborne route (during the infectious period)	‘A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when: • caring for patients with a suspected or confirmed infection spread predominantly by the airborne route (during the infectious period)

A common feature of all three iterations was that nowhere did they state whether SARS-CoV-2 was spread by the airborne route “wholly”, “predominantly” or “not at all”. In fact it gave no clear direction on the subject at all. The last thing one needs in a pandemic emergency is uncertainty and dithering as to when respiratory protection is needed and when it is not. The IPC guidance spectacularly ducked the issue – as it still does in the National IPC Manuals today.

8.5. IPC guidance – predominantly vague

From early 2022 right through until the present day, the use of the terms “predominant transmission” and “predominant spread” have continued to be used in relation to SARS-CoV-2 and decisions as to whether RPE should be worn or not.

Even the Minister, Rt Hon. Ashley Dalton MP is on record, as recently as June 2025 in asserting that “The Government position ... is that SARS-CoV-2 ... is **not predominantly** spread via the airborne route”. She does, however know that it can be transmitted by the airborne route and, confusingly, goes on to confirm that scientific literature and public health documents confirm that COVID-19 **is predominantly** transmitted through the airborne route.

In any event, this is a futile and nonsensical argument for two very sound reasons:

8.5.1. 'Predominance' – no credible scientific basis

No defensible scientific evidence has ever been produced to support a definition of “predominantly” in respect of SARS-CoV-2 transmission. Let us consider the relative proportions of the 3 perceived transmission routes in the “continuum” referred to by Professors Curran and Wilcox as follows:

By Airborne/Aerosol is A%

By Ballistic Droplets is D%; and

By Fomite/contact with contaminated surfaces is F%. However, since the 4 CMOs, in their report (Dec 2022)¹⁵² say that F% is around 1 in 10,000 (=0.01%) it can be discounted. The CDC in America had been saying this as far back as April 2021¹⁵³

So, in order for anyone to claim that “the airborne route is not predominant”, there must exist some sound, peer-reviewed scientific evidence which proves that D% is greater than A%. That is not the case according to the COVID-19 Inquiry’s appointed expert in aerosol science and disease transmission, Professor Clive Beggs.

8.5.2. 'Predominance' – irrelevant in law

One would hope that the Government, its Departments, Agencies and the NHS would respect the law of the land, namely the COSHH Regulations. If a hazardous substance (including pathogenic viruses) is inhalable¹⁵⁴, as is the case with aerosols (or “short range inhalation of aerosolized infectious respiratory particles” to use the latest WHO terminology) then Respiratory Protective Equipment is mandatory where other methods of control cannot achieve adequate protection. Much has been said about the “hierarchy of controls” and indeed it has been abused and misused by IPC personnel.

The bottom line is that for a doctor, nurse or other healthcare worker providing close quarter care of a confirmed or suspected infectious patient, the other elements of the hierarchy are irrelevant and RPE is the only control measure. A possible exception may be where there is local exhaust ventilation around the bed-head which is sucking the patient’s infectious aerosols away, though RPE may still be advised.

This is perhaps better illustrated with a perfectly valid analogy, namely car-body paint spraying. Here we have potential for all routes of transmission:

- Direct **contact** of the paint and solvents with the skin;
- **Droplet** contact from the fine mist generated by the paint spray itself, which can land on the skin and be inhaled, impinging on the mucosa in the nose/mouth; and
- Inhalation of the **airborne** solvent vapours.

The COSHH Regulations require the employer to consider **all** transmission routes. The notion that an employer could disregard any one of the above routes of transmission and therefore not provide the necessary PPE on the grounds that “it is not the predominant route and therefore doesn’t matter” would most likely result in immediate enforcement action against them – including prosecution if anyone died or sustained serious ill-health as a result.

¹⁵² UK Chief Medical Officers : Technical Report on the COVID-19 pandemic in the UK : Page 50, paragraph 3 ([Link](#))

¹⁵³ Centres for Disease Control & Protection (CDC): SARS-CoV-2 & Surface (Fomite) Transmission for Indoor Community Environment ([Link](#))

¹⁵⁴ “Inhalable” is, in occupational health and safety, defined as solid or liquid particles which are less than 100 microns in size.

“Inhalable” in the meaning of the latest WHO terminology is the entry into the nose/mouth of “Infectious Respiratory Particles”
i.e. Particles composed of water and other constituents containing viable pathogens exhaled in a wide range of sizes by people infected with a respiratory pathogen

9. The IPC Cell's sensitivity to 'reputational risk'

As the pandemic progressed through the second wave, a groundswell of complaint was generated by stakeholder organisations such as the AGP Alliance (predecessor of CATA), the BMA, RCN, RCM, Unions etc. Letters had been sent to the Prime Minister, the Secretary of State, MPs, the Chair of the Health and Social Care Select Committee, the Scottish Government, the Chief Nursing Officer (England), individual Members of Parliament, the HSE and Public Health England. This chorus of concern was largely met with silence from state bodies, or carefully-crafted standard letters expressing “thanks for the dedicated work of the healthcare workforce”, that “their safety was Government’s top priority”, how the Government was “working tirelessly to deliver PPE” and the “IPC guidance was under constant review by its experts”. These trite statements and the lack of any positive action merely served to exacerbate the situation and worsen morale amongst the healthcare workforce.

Stakeholders issued public statements, widely circulating in the media, that they were unable to get the PPE that they needed to remain safe – and all the time the appalling tragedy of doctors, nurses and other healthcare workers dying and becoming seriously ill was plain for everyone to see, let alone the horrific levels of patient deaths through nosocomial infection.

Presumably the IPC Cell were made aware of these representations and one might wonder how they responded.

Unfortunately no further details can be provided for the remainder of this section as the information is drawn from the minutes of IPC Cell meetings which the Inquiry Chair has not yet authorised to be released into the public domain

The relevant INQ number is retained in the footnotes for future reference as and when it is published

Some relevant documents relating to an open letter by CATA’s health and safety advisor to Ms Sarah Albon, CEO HSE may be found at this link ¹⁵⁵

¹⁵⁶ ¹⁵⁷

10. ARHAI uncloaked

In section [2.3.1](#) the credibility of ARHAI technical information was called into question i.e. its rapid review into the emergence of the Alpha/Kent variant during December 2020. That review provided incorrect and misdirecting information to the IPC Cell at a critical point during the second wave. Some Cell members were proposing a precautionary approach to extend RPE beyond AGPs for all patient-facing HCWs. ARHAI’s conclusion was that it was not necessary to adopt the extend the use of RPE beyond AGPs. The ARHAI paper was clearly highly influential on Cell members since it ‘won the day’ against a contrary proposal from PHE to follow a more precautionary approach and provide all patient-facing HCWs with RPE. As a consequence, workers were left improperly protected against the virus.

It was also noted that none of the ARHAI ‘rapid reviews’ mentioned that the ECDC guidance was recommending FFP2/3 respirators for all HCWs in Europe caring for suspected or confirmed COVID patients, despite this having begun in June 2020.

¹⁵⁵ Letter to Sarah Albon, HSE : Allegation: Offences committed by members of the NHS Four Nations IPC Cell etc under section 36, Health and Safety at Work etc Act 1974 (7 February 2022) ([Link](#)).

Ensuing correspondence: From S. Albon (14 Mar 2022) ([Link](#))

Reply to S. Albon (14 Mar 2022) ([Link](#))

S. Albon terminates correspondence (4 Apr 2022) ([Link](#))

¹⁵⁶ INQ000398178

¹⁵⁷ INQ000398189

It was also noted that ARHAI, although clearly cognisant of the EMG's technical papers reporting the airborne nature of COVID-19 transmission, failed to include this information in their 'rapid reviews of the literature'.

Although this report is primarily concerned with the conduct of the IPC Cell, due to the compelling influence of ARHAI (via its rapid reviews and its representatives in the Cell), it is considered appropriate to review some of ARHAI's other 'rapid reviews' to explore whether the above deficiencies were replicated in their later reviews.

10.1. ARHAI consideration of the Skagit County Chorale super-spreading event

This links back to the Dr Colin Brown's advocacy for the precautionary approach mentioned above, where a major driving factor was the increased knowledge about airborne transmission. Following Dr Ritchie's consultation with Cell members, Laura Imrie returned an email opposing the PHE initiative, stating:

"There is no clear evidence of airborne transmission. The references provided at the end of the scientific brief largely consist of outbreak reports from restaurants, sports settings and a choir practice. There are unfortunately no air sampling studies to provide a more detailed analysis of these settings/scenarios."¹⁵⁸

Her reference to the choir practice related to the super-spreading event at the Skagit County Chorale which PHE had mentioned as part of the evidence for increased airborne transmission. It should be noted that this paper was authored by a group of highly qualified and widely respected specialists in aerosol science and related disciplines.¹⁵⁹

ARHAI included mention of the Skagit paper in their next rapid review (January 2021) where it was dismissively referred to as an "outbreak report"¹⁶⁰:

"Outbreak reports are, by their nature, prone to many methodological limitations (e.g. self-report bias, publication bias, lack of robust data)."

Whilst accepting that some outbreak reports may well be described in this way, the Skagit paper by Miller et al should not be categorised as such. The distinguished authors would most likely find the insinuation about bias insulting if not impugning of character. ARHAI understates the strength of evidence this paper provides regarding aerosol transmission. The researchers integrated epidemiological reconstruction with quantitative aerosol science i.e.:

- They worked backwards from the number of people who became infected to estimate approximately how much virus the index case must have been emitting into the air.
- They took account of practical environmental factors such as the size of the room, the duration of the rehearsal, and the level of ventilation.
- They explored a range of realistic "what-if" scenarios to see how infection risk would change if conditions were different (for example, better ventilation or a shorter rehearsal), and the results varied exactly as expected if airborne transmission were the dominant route.
- They assessed whether the outbreak could plausibly be explained solely by close-range droplet spread or contaminated surfaces, and concluded that those mechanisms did not adequately fit either the scale or the spatial pattern of infections.
- They also considered whether additional asymptomatic infectious individuals might have been present and contributed to transmission, but explained why this was very unlikely given the very low community prevalence of COVID-19 at the time.

¹⁵⁸ Email Chain between Laura Imrie and members of the UK IPC Cell (23 December 2020) ([Link](#)) ([Alt Link](#)) (INQ000348370 : pages 1 and 2 only)

¹⁵⁹ Transmission of SARS-CoV-2 by inhalation of respiratory aerosol in the Skagit Valley Chorale superspreading event (15 Sept 2020) ([Link](#))
Authors: Shelly Miller, William Nazaroff, Jose L. Jimenez, Atze Boerstra, Giorgio Buonanno, Stephanie Dancer, Jarek Kurnitski, Linsey Marr, Lidia Morawska, Catherine Noakes

¹⁶⁰ ARHAI : Rapid review of the literature : Assessing the IPC measures for COVID-19 in health & care settings (15 January 2021) ([Link](#))

Although there are always some limitations associated with all ‘real-world’ studies, the Miller report applied well-established physical and engineering principles to outbreak data. ARHAI and the IPC Cell should have paid greater attention to the findings of this important research.

A number of other ‘rapid reviews’ have been checked to see if these examples are indicative of any trends. We will start with their rapid review (#15) dated 11 June 2021.¹⁶¹

10.2. ARHAI consideration of SAGE paper S1169 “Masks for healthcare workers”¹⁶²

In this review, ARHAI selected a single sentence from this 28-page SAGE paper which we shall consider below, but first we need to consider the context in order to appreciate its significance.

On page 6 of their rapid review, just before discussing S1169, ARHAI note that the American Centres for Disease Control and Prevention (CDC) and WHO both describe what they refer to as ‘short-range aerosol’ transmission and explain that ***“the respiratory aerosols remain suspended in the air thus increasing the risk of transmission”***. ARHAI then state:

“This is a move away from the historical dichotomy of droplet vs. airborne, instead acknowledging that an aerosol produced at source will also present the risk of being transmitted at close range (e.g. within 2 metres)”.

At first sight, this suggests the possibility of a shift towards recommending wider use of airborne precautions. After all, most healthcare activity by doctors, nurses, paramedics and other HCWs takes place within 2 metres of patients, and close-contact care would logically warrant respiratory protection against aerosol inhalation that cannot be provided by surgical masks.

However, this statement is immediately followed by a choice quotation from SAGE S1169:

“The UK Scientific Advisory Group for Emergencies (SAGE) in April 2021 stated that evidence suggests airborne transmission is most likely in poorly ventilated spaces but that applying full conventional airborne precautions throughout a hospital is neither practical nor likely to be necessary”.

While it is true that a requirement for every person to wear FFP3s at all times in every part of a hospital would neither be practical nor necessary, this does not address the previous point about short-range aerosol risk. We are not discussing people in offices or casually walking around corridors; we are discussing close interactions where a HCW is at risk of inhaling the aerosol plume emitting from a patient due to natural physiological processes (breathing, talking, coughing etc). This aerosol plume is emitted whether the patient is wearing a surgical mask or not. The comment about hospital-wide impracticality has no bearing whatsoever on the delivery of close-contact care.

10.3. ARHAI’s consideration of Whole Genome Sequencing

By way of explanation, Whole Genome Sequencing (WGS) may be considered analogous to ‘DNA fingerprinting’, though it is far more precise. It can indicate whether two infections are genetically consistent with one person having infected another, especially when combined with other evidence, and is therefore a valuable tool for outbreak investigation.

Shortly after the discussion about ‘outbreak reports’, ARHAI concluded:

“Without a detailed epidemiological investigation, ideally with whole genome sequencing, it is very challenging to obtain data from outbreak reports that provides reliable and valid assessment of the potential transmission modes.”

¹⁶¹ ARHAI : Rapid review of the literature : Assessing the IPC measures for COVID-19 in health & care settings (11 June 2021) ([Link](#))

¹⁶² SAGE Paper S1169 : ([Link](#))

It then went on to reference a study (Safdar et al) where WGS had been used to confirm that a HCW had been infected in the community and not by the two patients for whom the HCW had been caring.¹⁶³ The paper is interesting in that it set out to address concerns about whether HCWs are adequately protected from exposure by FRSM while caring for patients. The HCW was wearing a surgical mask, face shield, gowns and gloves. WGS determined that the HCW had been infected by a family member, not the patients. The authors concluded that **“this offers reassurance to HCWs currently treating COVID-19 patients that appropriate PPE protects against hospital-acquired SARS-CoV-2 infection.”** It has to be said that this is an extraordinarily bold statement given that the study only considered one individual HCW’s infection and would likely only have scored “Low” (if not “very low”) using the GRADE¹⁶⁴ evaluation tool which ARHAI are understood to use. It is therefore surprising that ARHAI accepted it into evidence. ARHAI’s use of this was to state **“Genetic sequencing provided confirmatory evidence for community transmission to a HCW, ruling out suspected transmission from two COVID-19 patients”** which gives a very positive, but totally misleading message inferring that ‘patient-to-staff’ transmission is “ruled out” in comparison with contracting the infection in the community.

However, the reason for highlighting the Safdar paper is to illustrate what ARHAI had **not** reported. There was another study undertaken by Klompas et al which used WGS but gave a contrary message since it showed that three cases of transmission **had** occurred despite the wearing of surgical masks (including one instance where both parties were masked).¹⁶⁵ Again, this would most likely have scored low via the GRADE system.

According to ARHAI’s stated search methodology, the Klompas study should have been picked up. Its exclusion, while Safdar was cited, makes the treatment of these small observational studies seem inconsistent — and since this evidence in the ‘rapid reviews’ helped inform IPC Cell decisions, that inconsistency really needs explaining.

10.4. ARHAI’s consideration of a major Scottish study

ARHAI were fortunate to have available to them the output from a truly comprehensive study by Dr Anoop Shah and colleagues, which examined the impact of COVID-19 on over 150,000 healthcare workers (of which over half were patient-facing) and their families.¹⁶⁶ This was a well-designed study which sub-divided HCWs into two categories, described as ‘front door’ and ‘others’. ‘Front door’ HCWs were classified as being involved in the higher risk activities, both in intensive-care and non-intensive-care settings, including paramedics and HCWs in acute receiving specialties, HCWs in respiratory medicine. This enabled a more precise analysis of those who were at greater risk serving in the ‘front-line’.

The results showed that one sixth of all COVID-19 cases admitted to hospital were healthcare workers or members of their households. The risk of patient-facing HCWs had a threefold increased risk of admission and their families a twofold increased risk of admission. Of patient-facing HCWs those categorised as ‘front door’ HCWs were at twice higher risk of hospitalisation than the ‘other’ cohort of HCWs.

If proof was needed that improved protection of patient-facing HCWs was urgently needed, this was it. These stark figures ought to have set red flags flying. As the authors acknowledged **“these findings have implications for the safety and wellbeing of healthcare workers and their households”**. However no suggestions were offered as to risk reduction/mitigation measures. Although this may have been beyond the scope of the research project one would hope that ARHAI would have brought these figures to the IPC Cell’s attention and Dr Jim McMenamin (a co-author of the Shah paper) may have brought these figures to NERVTAG’s and SAGE’s attention as a matter of concern (being a member of both NERVTAG and SAGE). The minutes of these various meetings have not been checked but the salient

¹⁶³ Determining the source of transmission of SARS-CoV-2 infection in a healthcare worker, Safdar et al (1 May 2020) (Preprint) ([Link](#))

¹⁶⁴ GRADE : “Grading of Recommendations Assessment, Development and Evaluation” tool (rates the quality {certainty} of evidence)

¹⁶⁵ Transmission of SARS-CoV-2 from ... individuals in healthcare settings despite medical masks and eye protection (11 March 2021) ([Link](#))

¹⁶⁶ Risk of hospital admission with COVID-19 in HCWs and their households: nationwide linkage cohort study : Shah et al (11 Sep 2020) ([Link](#))

point is that no action was taken – and these figures certainly should have informed the discussions around “precautionary approach” in December 2020.

ARHAI, in their rapid reviews accurately recorded the study:

“In Scotland, during the period 1st March-6th June, HCWs or their households made up 17.2% (360/2097) of all hospital admissions for COVID-19 in the working age population. Healthcare workers in patient-facing roles were at higher risk of hospital admission (hazard ratio 3.30, 2.13-5.13) than non-patient-facing HCWs, as were their household members (1.79, 1.10-2.91). Most patient facing healthcare workers were in “front door” roles (e.g. paramedics, acute receiving specialties, intensive care, respiratory medicine). Those in non-patient-facing roles had a similar risk of hospital admission as the general population”

However, the ARHAI authors then seem to play down the obvious nosocomial infection rate impacting front-line HCWs by shifting the focus towards community transmission rather than nosocomial infection. They continued from the above paragraph by citing a study of an English cohort of HCWs:

“This was not the case in an English cohort; screening of 1654 symptomatic HCWs by an English NHS Trust between March 10-31st identified 240 (14%) positive individuals; comparison of rates between staff in patient-facing and non-patient facing roles found no evidence of a difference, suggesting that data may reflect wider patterns of community transmission rather than nosocomial-only transmission.”

However, ARHAI do not make a fair comparison between the two studies, comparing the Shah study with the English screening study of symptomatic healthcare workers. The two are very different and not directly comparable. Shah looked at hospital admissions across the whole Scottish workforce and found patient-facing staff were clearly at higher risk. The English study was just a short snapshot at one hospital, checking who tested positive among symptomatic staff, without following outcomes or adjusting for other factors. Not finding a difference in that small local sample does not prove that patient-facing roles aren’t riskier — it just means the study wasn’t designed to detect it. Large, population-wide analyses like Shah are much more reliable for assessing occupational risk.

ARHAI’s failure to take proper account of the Shah study is a matter which needs explaining – as does the fact that a trend seems to be emerging that, whenever an adverse finding is recorded which suggests insufficient mitigations are in place for HCWs, there immediately seems to be a selected study which detracts from it but which does not seem to be a fair like-for-like comparison.

10.5. ARHAI misrepresenting HSE position on PPE

There were 2 notable occasions when ARHAI quoted HSE as an authoritative source of information:

- An online response to the RCN report, critical of the ARHAI ‘rapid reviews’; and
- Statements embedded within their ‘rapid reviews’

Both of these carried misinformation (or ‘disinformation’ depending upon one’s viewpoint). From his knowledge of the HSE over the previous 25 years and a serving member of the HSE’s committee, the ‘COSHH Essentials Working Group’, CATA’s Health and Safety Advisor did not consider it likely that HSE would have said any of these things as reported by ARHAI and the IPC Cell. He wrote to HSE’s Chief Executive drawing her attention to these alleged statements.¹⁶⁷

10.5.1. ARHAI online response to a report by the Royal College of Nursing

On 6 Apr 2021 ARHAI published a response to the paper produced on behalf of the RCN by Professor Dinah Gould and Dr Edward Purssell.¹⁶⁸ The ARHAI response read as follows:

¹⁶⁷ Letter to Ms Sarah Albon (CEO, HSE) Respiratory Protection for healthcare workers (16 May 2021) ([Link](#))

¹⁶⁸ RCN Independent review of guidelines for the prevention and control of Covid-19 in health care settings in the UK (28 Feb 2021) ([Link](#))

The RCN report is seriously flawed in its premise, as it incorrectly assumes the UK IPC guidance is based on this ARHAI rapid review. The RCN report did not reflect that the UK COVID-19 IPC Guidance is based on the UK IPC pandemic response guidance, agreed by NERVTAG, and is fully aligned with that of the World Health Organisation IPC guidance recommendations published to date. The Health and Safety Executive have approved the PPE section within UK IPC COVID-19 guidance.

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After this was drawn to Ms Albon's attention, a reply was received from the Acting Lead of the HSE's Health and Social Care Services Unit.¹⁷⁰ The above statement was flatly denied:

"I can advise that HSE are not involved in directing, influencing, or supporting PHE/DHSC PPE policy in relation to the COVID-19 infection prevention and control guidance for healthcare settings. The Department of Health & Social Care (DHSC), working closely with Public Health England (PHE) and the devolved administrations, is the lead Government department for the UK response. It is those bodies who are responsible for developing and publishing the guidance that is agreed and applied across the four nations.

HSE has been consulted and provided technical input on request to those responsible for the guidance; HSE is not however responsible for or has 'approved' the guidance."

10.5.2. ARHAI infer that it is HSE dictating that FFP respirators must not be used other than for AGPs

In the ARHAI 'rapid review' in February 2021 the following sentence was introduced.

The UK Health and Safety Executive (HSE) position regarding RPE has remained unchanged; currently the use of respirators, such as FFP2 or FFP3, are only for the highest risk aerosol generating procedures which are undertaken in medical settings and during dental procedures (*correspondence provided by the UK IPC Cell*).

At first sight, this certainly looks like a dictat from HSE that FFP2/3 respirators must **not** be used beyond AGPs. The statement effectively puts the whole might of the UK's Regulatory and Enforcement body behind this element of the IPC guidance. It will no doubt have been highly influential on anyone reading it.

It was, as we shall see, a complete fabrication by ARHAI and was a distortion of the HSE's stated position. Given the context at the time (at the height of the second wave) this is a particularly serious matter which warrants further investigation. It is not for CATA to make judgments, simply to lay out the facts for others to consider.

CATA's H&S Advisor did not believe that HSE would ever say this. The position HSE **always** takes is that it is the duty-holder's responsibility to undertake risk assessments and then implement the risk control measures which will be the most effective, having due regard to 'reasonable practicability'. That is not only the HSE's position, it is the law of the land. It is not HSE's responsibility to undertake risk assessments on behalf of employers.

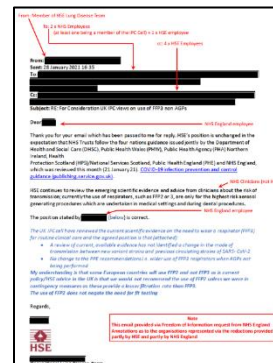
FoI requests were submitted to HSE and NHS-E for the correspondence referred to between HSE and the IPC Cell.

HSE's initial response to this FoI request was "***We have no knowledge of such communication***".

¹⁶⁹ ARHAI online response to the RCN review (6 April 2021) ([Link](#))

¹⁷⁰ Letter from Acting Lead, Health and Social Care Services Unit (17 June 2021) ([Link](#))

Nine months later, NHS-E provided a copy of the actual email from HSE which had been sent to the IPC Cell. This was heavily redacted (quite properly). However, further information obtained from HSE and NHS-E has enabled the organisations for which the individuals worked to be identified and annotated in order to assist interpretation. This can be accessed at the link in the footnote.¹⁷¹



By comparison of (a) the text in the ARHAI 'rapid review' with (b) the actual email from the HSE we can see how the HSE Inspector's words have been manipulated by the ARHAI 'rapid review' author with an outcome portraying a completely different message from that originally intended by the HSE Inspector.

Two separate clauses, originally considerably separated from each other, have been extracted and merged together to give a combined sentence which completely misrepresents the HSE Inspector's original intention.

(a) HSE Inspector's email (as originally written)	Thank you for your email which has been passed to me for reply. HSE's position is unchanged in the expectation that NHS Trusts follow the four nations guidance issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS)/National Services Scotland, Public Health England (PHE) and NHS England, which was reviewed this month (21 January 21). COVID-19 infection prevention and control guidance (publishing.service.gov.uk). HSE continues to review the emerging scientific evidence and advice from clinicians about the risk of transmission; currently the use of respirators, such as FFP2 or 3, are only for the highest risk aerosol generating procedures which are undertaken in medical settings and during dental procedures.
(b) HSE Inspector's email (as 'adapted' by author of ARHAI rapid review)	The UK Health and Safety Executive (HSE) position regarding RPE has remained unchanged; currently the use of respirators, such as FFP2 or FFP3, are only for the highest risk aerosol generating procedures which are undertaken in medical settings and during dental procedures (correspondence provided by the UK IPC Cell).
How was this done?	Thank you for your email which has been passed to me for reply. HSE's position is unchanged in the expectation that NHS Trusts follow the four nations guidance issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS)/National Services Scotland, Public Health England (PHE) and NHS England, which was reviewed this month (21 January 21). COVID-19 infection prevention and control guidance (publishing.service.gov.uk). HSE continues to review the emerging scientific evidence and advice from clinicians about the risk of transmission; currently the use of respirators, such as FFP2 or 3, are only for the highest risk aerosol generating procedures which are undertaken in medical settings and during dental procedures.

We must remember that, extraordinarily, HSE inspectors were under strict orders to regard the 4-nations IPC guidance as the definitive standard against which they should regulate (as opposed to health and safety legislation such as COSHH). This was discussed in section 5.3 above, with statements by HSE officials:

- (a) _____; and
- (b) _____.

¹⁷¹ Email HSE to IPC Cell : HSE's expectations regarding NHS Trusts compliance with IPC guidance (28 Jan 2021) (annotated) ([Link](#))

With this in mind, it can be seen that the HSE inspector's email was simply confirming that this position had not changed. They expected duty holders such as NHS Trusts to strictly comply with the IPC guidance – that had been HSE's enforcement brief since the outset of the pandemic and their position on this had not changed.

We should now consider the other point the Inspector makes as regards respirators. The HSE Inspector was simply working on the basis that they had been informed by clinicians working for the NHS that, **as a result of their own risk assessment**, FFP2 or 3 respirators were only to be used for highest risk AGPs undertaken in medical settings. It is clear that **HSE were not stating that this was their advice**. The alteration of this text results in a very different interpretation of HSE's position and accounts for the subsequent request by HSE for the removal of the text from the ARHAI documents once this error and misinterpretation had been brought to their attention.

† HSE have confirmed directly to CATA's health and safety advisor that the "clinicians" referred to by their colleague were **NHS clinicians** (not HSE).

Given the importance of matters pertaining to the respiratory protection of healthcare workers (with health and wellbeing at stake on one hand and permanent disability and death on the other) and the fragility of the IPC Cell's and ARHAI's position that FRSMs would keep them safe, the distortion of the HSE email is considered to be an extremely serious matter.

The ARHAI author's misrepresentation of the HSE Inspector's words can hardly have been done by accident or mistake. It would be for lawyers to determine whether this constitutes misconduct and, if so, the status of this in terms of legislation. The Inquiry is invited to review this matter and make such recommendations as it sees fit.

The Acting Lead of the HSE's Health and Social Care Services Unit, who replied to our letter confirmed "***We have considered the ARHAI statements further, and we agree that the lines quoted in your letter appear misleading. We therefore intend to contact ARHAI to clarify. Thank you for once again bringing these to our attention.***".

No details of the conversations or correspondence between HSE and ARHAI are available. However, the statement derived from the HSE email last appeared in the September 2021 edition of the ARHAI 'rapid reviews' and was gone in the October edition.¹⁷² The fact that it disappeared is proof, in its own right, that HSE did not support the statement and forced ARHAI to remove it. Otherwise, such a powerful statement in support of the IPC Cell's guidance would most likely have endured in perpetuity as it would be unlikely they would want to remove it voluntarily.

Although the alteration of an email and publication of one misleading statement may appear to be a fairly localised matter around the time of the second wave, when we delve deeper we find that the evidence provides valuable insight into HSE's position regarding the DHSC/PHE/NHS use of surgical masks as opposed to respirators. This can be seen:

- (i) in an email from Professor Jonathan Van Tam which confirms that the decision to use FRSMs was entirely down to clinicians and not HSE – and in fact HSE had always preferred FFP3 as optimal protection, advice which clinicians had rejected.
- (ii) in notes of an IPC Cell meeting with HSE and an email from a senior HSE official shortly afterwards where we see that the decision to provide FRSM was based on NHS's own risk assessment almost a year earlier.

Considering these in turn:

- i) In Professor Van Tam's email (23 Jan 2020), he explains the divergent historical positions of HSE vs clinicians in respect of respirators/masks.¹⁷³ He was ideally positioned to explain this, having personally advised the Department of Health on masks and respirators since 2004, including advice on the types of masks and respirators to be stored in the pandemic flu stockpile i.e. FFP3 respirators only for intensive care units and AGPs, with all other healthcare workers being equipped with FRSM:

¹⁷² Access to all ARHAI 'Rapid Reviews of the Literature for COVID-19 IPC' may be found at [this link](#).

¹⁷³ Email: Professor Jonathan Van Tam to colleagues (23 January 2020) ([Link](#))

“The historical HSE statutory position is that maximum level RPE is required. This was neither affordable nor practical for pandemic stockpiling. The difference between Public Health/clinicians and HSE’s statutory view point have to my knowledge never been resolved.”

- ii) On Friday 31 January 2020 a meeting was held between HSE and IPC personnel at which PPE issues were discussed in relation to the impending pandemic.

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On Monday 3rd February 2020 the Head of HSE’s Emergency Planning Unit wrote to NHS-E’s Head of Infection Control giving HSE’s formal response to the issues which had been discussed at the previous Friday’s meeting. 175
This evidences that HSE respect duty-holders’ risk assessment and determine risk controls for themselves. HSE have historically not intervened or overridden decisions made by clinical specialists about medical matters.

10.6. Top-level responsibility/accountability for the quality/accuracy of ARHAI’s information

The most senior and influential committee within the Scottish Government was the ‘COVID-19 Nosocomial Review Group’ (CNRG). This was established by the Scottish Government as a time-limited expert group which provided expert advice and guidance to inform the Scottish Government at the highest level i.e. Ministers, the Chief Nursing Officer, the Chief Medical Officer, National Clinical Director and other Health and Social Care Directors.

The two individuals with overall responsibility for the content and accuracy of the ARHAI guidance documents (*and therefore accountable for the ‘adaptation’ of the HSE email*) were:

- Professor Jacqui Reilly (Chair) (also Chair of the Independent High Risk AGP Panel); and
- Ms Laura Imrie (Lead consultant for the National ARHAI service, also member of IPC Cell).

The CNRG Chair would periodically issue formal advice notes in order to inform Ministers, CNOs etc (as above). 176

10.7. ARHAI misinformation concerning the similarity in protective effect of FRSM vs FFFP3

Finally in this section we will look back to the early days of the pandemic – specifically to the first edition of the 4-Nations IPC guidance issued mid March 2020 which was the point at which respiratory protection was abandoned in favour of surgical masks.

One of the main points that DHSC, PHE and NHS leaders required was for the IPC guidance to recommend FRSMs for ‘protection’ of HCWs given that the pandemic planners misunderstood the routes of transmission of influenza and coronaviruses and now there was a critical shortage of respirators across the world. Those responsible for drawing up the revised guidance which would mandate FRSM for most health and social care workers needed to come up with some sort of seemingly valid justification in an attempt to allay the inevitable concerns of HCWs and avert any possible ‘refuse to treat’ response in view of the extreme risk to their health and safety – and indeed to their very lives and that of their family members.

The paper they selected to justify the downgrade was a paper by Vittoria Offeddu et al. 177

¹⁷⁴ INQ000398129

¹⁷⁵ Email: Head of HSE Emergency Planning Unit to NHS-E Head of Infection Control : confirmation of IPC risk assessment for use of FRSM ([Link](#))

¹⁷⁶ INQ000242085

¹⁷⁷ Offeddu et al: ‘Effectiveness of Masks & Respirators Against Respiratory Infections in HCWs: A Systematic Review and Meta-Analysis’ (2017) ([Link](#))

ARHAI, in the first edition of their ‘rapid reviews’ (published mid-March 2020) stated the following, based on the Offeddu paper.

“A systematic review and meta-analysis of observational studies conducted pre-COVID-19 found a protective effect of up to 80% for masks and respirators used by healthcare workers against SARS-CoV however the existing evidence base was sparse and indications (and compliance) for mask/respirator use varied between studies.”

Version 1.0 of the 4-Nations IPC Guidance (published 13 March 2020) stated:

“For SARS-CoV, evidence suggests that use of both respirators and surgical face masks offer a similar level of protection, both associated with up to an 80% reduction in risk of infection”

The deficiencies and limitations of the Offeddu paper mentioned by ARHAI (“sparse” etc) were noticeably absent from the IPC guidance.

In the weeks following the PPE downgrade, the clamour of discontent amongst doctors, nurses and other healthcare workers rose to fever-pitch. The Commons Health and Social Care Select Committee heard evidence of one London A&E doctor saying:

“It’s absolute carnage in A&E, utter chaos. We don’t have any proper PPE. We are being given paper masks, not the gowns, not the FFP3 masks we need ... I am in shock. I feel like we are being thrown to the wolves here. Some of us are going to die.”

Professional Institutions across the UK became exceedingly concerned and were flooded with calls from members, many of whom were frightened for their lives. Three experts wrote to Mr Duncan Selbie, Chief Executive of Public Health England raising concerns about the competency of those responsible for producing the IPC guidance and, specifically, their reliance on the Offeddu paper.¹⁷⁸ They said:

“We write to raise our specific concerns about the competence of the generic occupational health and safety risk assessment which has informed the advice about the safety and protection of HCW during the COVID-19 pandemic written by a number of official bodies including Public Health England”

“Your advice seems to be largely, but not exclusively based on the on the Offeddu et al systematic review and meta-analysis, which broadly concluded that both the surgical mask and the FFP3 respirator both achieve similar protection”.

“We believe the dependence on this meta-analysis is flawed, because it is based on low quality papers and as concluded within the meta-analysis it did not take into account the generally poor compliance with use of PPE in the studies.”

This letter appears to have found its mark since the claim of an “80% risk of reduction in infection” was removed from the next iteration of the IPC guidance published in April 2020.

However, this misinformed and incorrect claim persisted in the ARHAI guidance right the way through until the final edition was published in April 2022. Furthermore, and more disturbingly, Prof Jacqui Reilly was_____

_____. Key decision-makers would hardly see any need to increase protection to FFP3 if their appointed expert was telling them that they both provide a similar level of protection as each other. One would have hoped that the letter from Professor Macdonald and colleagues would have resulted in closer scrutiny of the ARHAI rapid reviews and removal of this inaccurate information. As highlighted by Macdonald et al ARHAI’s position was not founded on strong research evidence and, as illustrated below, ARHAI failed to properly acknowledge the many limitations and caveats embedded in the Offeddu report, either through having not read it properly or having selectively ignored evidence which didn’t suit their objective.

For the sake of completeness we shall review the Offeddu paper with the same critical eye as Prof Reilly, Ms Imrie and colleagues in ARHAI/IPC Cell should have done. Within the paper, Dr Offeddu herself acknowledged the following limitations and confounding factors, over and above those few already mentioned by ARHAI:

¹⁷⁸ Letter to D Selbie (PHE, CEO) from Prof Macdonald, Prof Cherrie, Dr Martyn - Improving the Protection of HCWs during the pandemic (26 Mar 2020) ([Link](#))

- In respect of Randomised Control Trials:
 - ***“Assessment of clinical outcomes was self-reported and prone to bias”;***
 - ***“Evidence of a protective effect of masks or respirators against Viral Respiratory Infection ... was not statistically significant, though this may indicate insufficient statistical power in these studies, rather than lack of a protective effect”***
 - ***“The source of infection was not ascertained in any of the trials; some HCWs may have acquired infections in the community rather than the workplace”.***
 - ***“...one RCT required HCWs to wear rPPE only when caring for febrile patients... whereas others specified continuous rPPE use...”*** (rPPE = ‘Respiratory Personal Protective Equipment’ = RPE)
 - ***“...our meta-analyses included RCTs with different comparison groups, including convenience samples of HCWs not usually wearing masks... or following routine infection control policies...”***
 - ***“The number of RCTs was small, and four of these were conducted in China by the same investigators, limiting generalizability to other settings.”***
- Limitations of included studies:
 - ***“Specific brands, models, or even the generic type of mask used, was often omitted.”***
 - ***“Several studies adjusted for confounders ... but it was not always clear which factors were accounted for.”***
 - ***“Most studies lacked statistical power to estimate protective effects, yielding extremely wide confidence intervals. Failure to detect a significant effect may therefore indicate insufficient statistical power... even when the available studies are pooled...”***
- Limitations of the Meta-Analysis of Observational Studies:
 - ***“It was not possible to account for potential between-study differences in exposure, fluctuating compliance with rPPE use, potential decreases in infectiousness over the course of the outbreak, or additional confounders affecting the original studies.”***

Crucially, this warning to policy-makers which CNRG/ARHAI should have taken note of:

 - ***“Overall, the evidence to inform policies on mask use in healthcare workers is poor, with a small number of studies that is prone to reporting biases and lack of statistical power”***

If the experts in ARHAI and CNRG had properly studied and understood the paper in question they should have appreciated these numerous limitations and not placed so much reliance upon it. It is highly probable (but for others to determine) whether this fundamental misinformation (arguably ‘disinformation’) caused widespread, avoidable infections and cost lives.

It should be emphasised that no criticism or disrespect is intended to Dr Offeddu or her colleagues who conducted their study and reported the results in good faith. It is unlikely that, at the time of publishing their paper in 2017, they would ever have dreamed that their research would be used as a justification to deny over a million healthcare workers proper respiratory protection in the midst of a global pandemic.

11. The Health and Safety Executive – AWOL from healthcare ?

Throughout the pandemic there has been an outcry from doctors, nurses and other healthcare workers on Twitter and other social media platforms along the lines of “Where is the HSE?”, “Surgical masks are obviously useless against this disease”, “How can HSE allow these IPC people to issue guidance that is killing and injuring us?”, “Why aren’t they doing something”.

In summary, there was a genuine, deep-seated feeling that the HSE had simply shrugged its shoulders and turned its back on the healthcare sector. Although HSE Inspectors carried out inspections of hospitals, their eyes were (at the instruction of their senior management) tunnel-visioned upon assessing compliance with Government guidance for social distancing, hand-washing etc, whilst turning a blind-eye to the obvious risk of infection through the wearing of surgical masks as if they were PPE/RPE.

Prior to 2020 the HSE quite deservedly enjoyed the reputation as a strong regulatory and enforcement agency with sweeping powers to ensure that employers protected the health and safety of their employees and others who might be affected by their activities. Its Inspectors used these powers wisely and effectively to encourage organisations to improve health and safety standards, but punished those whose acts or omissions caused death, serious injury or impairment of health with swingeing fines and/or jail sentences.

So how did this powerful, well-respected organisation come to have its ‘wings clipped’ during the pandemic? Why did it turn its back on the healthcare sector and leave the health, and indeed the very lives, of doctors, nurses and other healthcare workers in the hands of a relatively small number of individuals with limited competence and experience in occupational health and safety?

The answer, it seems, was a top down mandate from UK Government that HSE **must** do things differently in terms of their regulation and enforcement activities. Although no incontrovertible documentary proof has been found, persuasive evidence exists which demonstrates quite effectively that this was the case. The evidence will be laid out in this section.

11.1. ‘Behind closed doors’ meeting with DHSC

Some insight into the position that HSE found itself in during the pandemic can be gleaned by studying its enforcement of the RIDDOR¹⁷⁹ Regulations. Although RIDDOR has nothing at all to do with the IPC Cell or guidance, it is nevertheless relevant because it reveals how Government kept HSE under its thumb.

In the early stages of the pandemic, HSE guidance was very clear that HCWs who contracted the disease after treating patients with COVID-19 should be reported. In April 2020 it said that the employer must report “***if there is reasonable evidence that someone diagnosed with COVID-19 was likely exposed because of their work ... An example of work-related exposure to coronavirus would be a health care professional who is diagnosed with COVID-19 after treating patients with COVID-19***”.

On 12 May 2020, HSE CEO Sarah Albon was questioned by MPs in the Work and Pensions Select Committee.¹⁸⁰ During the evidence session and in their report the MPs were particularly scathing of HSE in respect of RIDDOR¹⁸¹. They reported that “***HSE concedes that the number of occupational deaths it has recorded through RIDDOR reporting is likely to be significantly lower than the reality, particularly in NHS settings. We are not persuaded that its efforts to tackle under-reporting have gone far enough or fast enough.***”.

This could be paraphrased as the MPs instructing Ms Albon to ensure that RIDDOR reporting improved as they were extremely concerned and wanted to know more about the impact that the pandemic was having on frontline HCWs.

However, shortly after that hearing, HSE changed the guidance for RIDDOR reporting in such a way as to ensure that this did not happen. The opposite happened. RIDDOR reporting was systemically suppressed by the wording in HSE’s guidance when the next edition was published, together with a ‘RIDDOR flowchart’ issued by NHS Employers (with HSE support) which bore no resemblance to the actual statutory requirements of RIDDOR.

This effectively instructed employers that if there had been compliance with the IPC guidance (e.g. wearing FRSMs) then that was considered to be a sufficiently effective control measure and such cases should not be reported. HSE actively turned away NHS Trusts/Boards attempting to report cases of HCW disease under RIDDOR (including deaths). Further information can be found in letters sent to NHS-Employers and HSE in March 2022.¹⁸² ¹⁸³

¹⁷⁹ Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

¹⁸⁰ Work and Pensions Select Committee : Oral Evidence: Health and Safety Executive (12 May 2020) ([Link](#))

¹⁸¹ Department of Work and Pensions: Response to the coronavirus outbreak ([Link](#))

¹⁸² Letter to NHS Employers re RIDDOR under-reporting (20 March 2023) ([Link](#))

¹⁸³ Letter to Sarah Albon, HSE re RIDDOR under-reporting (20 March 2023) ([Link](#))

One has to ask why the HSE would fail to comply with the requests of the elected MPs of this country, all of whom would have healthcare workers within their constituencies.

The answer became readily apparent when Ms Albon wrote to Sir Stephen Timms MP (Select Committee Chair).¹⁸⁴ In her response to the question about RIDDOR Ms Albon declined to answer, saying “**HSE has had discussions with a number of bodies, including Department for Transport (DfT) and the Department for Health and Social Care (DHSC). Whilst I appreciate the Committee’s interest, I am afraid these are subject to legal privilege and therefore cannot be released at this time**”. Hiding behind “legal privilege” is a legitimate tactic that is used when an organisation (the Government in this case) is anticipating having to defend itself against (for example) personal injury claims by employees for workplace exposure to hazards such as pathogenic viruses. By this time it was evident that the number of casualties amongst HCWs was fast increasing and future civil litigation was foreseeable.

This demonstrates a causal link between that meeting and HSE being instructed by Government how it will operate i.e. it is to regulate and enforce against Government’s IPC guidance as the base line, as opposed to health and safety regulations such as RIDDOR and, by extension, the COSHH and PPE regulations as well.

Government interference in the legal processes associated with health and safety legislation gives rise to valid questions about Government compliance with Article 2 of the EU Human Rights Convention (“Right to Life” etc) since there was no provision within the Coronavirus Act 2020 or associated Regulations to revoke or suspend any of these health and safety regulations. Although matters such as RIDDOR are not really within the scope of this report they are mentioned since they demonstrate how HSE was kept ‘on a leash’ by Government and Inspectors were not free to regulate as they would normally have done.

HSE Inspectors were, themselves, clearly unhappy about the measures that their senior management were forcing them to adopt. This can be seen in a speech by Mr Geoff Fletcher, HSE Inspector addressing the TUC Congress for the Prospect Trade Union¹⁸⁵:

“ Insufficient independence of HSE from Government resulted perversely in HSE telling Inspectors that they weren’t allowed to wear RPE when visiting site and also sites with outbreaks because COSHH did not apply, and that was just to fit in with the Government’s mantra of Hands, Face and Space.”

Mr Fletcher, as an inspector with 23 years of experience, certainly recognised that COSHH did apply. He would otherwise not have considered HSE’s ruling “perverse”.

CATA’s health and safety advisor agrees with Mr Fletcher. By way of analogy, if a person (HSE Inspector or otherwise) visits a site where they perceive that a hazard threatens their health and safety they, themselves are absolutely entitled to do whatever PPE they consider necessary to remain safe. Indeed it is not just an ‘entitlement’ they are under a legal duty to do so: “**It shall be the duty of every employee while at work to take reasonable care for the health and safety of himself...**”¹⁸⁶

Neither HSE Senior Management nor Governments have any legal right, nor any moral authority, to override this statutory provision. It is appalling that the HSE Chief Executive and her Directors pursued this course of action. It provides clear evidence of their kowtowing to Government and no doubt reflected a concern as to what message it would send to the public and HCWs if Inspectors visiting sites were seen wearing RPE. They considered this more important than the health and safety of their own Inspectors.

As discussed below, Mr Philip White (Director of Regulation) ‘held the pen’ on HSE’s internal risk assessment policy which denied Inspectors the right to use RPE. In the event that any HSE Inspector contracted COVID-19 within 14 days of visiting a site where there was an enhanced risk of infection such as hospital or elsewhere (e.g. an outbreak investigation) then Mr White may be held personally responsible and accountable.

¹⁸⁴ Letter from Ms Sarah Albon CEO, HSE to Sir Stephen Timms MP Chair W&P Select Committee (4 June 2020) ([Link](#)) (highlighted pages 6 & 7)

¹⁸⁵ Video : Trades Union Congress, Mr Geoff Fletcher, HSE Inspector, Prospect Trade Union (12 September 2023) ([Link](#))

¹⁸⁶ Health and Safety at Work etc Act 1974, section 7(a) ([Link](#))

11.2. HSE's own risk assessment methodology

A lot can be deduced about HSE's corporate views about the pandemic emergency and "toeing the Government line" by taking a look at its own risk assessment documents. HSE is no different from any other employer and is subject to Regulations 3 and 4 of the Management of Health and Safety at Work Regulations 1999 which require the employer to carry out a "suitable and sufficient assessment of risks to his employees" and institute risk controls in line with what is commonly referred to as the "hierarchy of risk controls".

CATA's health and safety advisor comments that, if the tables were turned and he was the Regulatory body reviewing the risk assessments of HSE as a dutyholder, he would have no hesitation in serving the HSE with an Improvement Notice for not having carried out a "suitable and sufficient" assessment in terms of protecting its staff against COVID-19. Furthermore, included in such an Improvement Notice would be a requirement for a new risk assessment to be carried out, this time by a competent person who properly understood the importance of protecting against the inhalation of infectious viruses by the airborne route.

HSE's risk assessments comprised two documents:

- (i) a text document setting out HSE Policy, a description of the various activities of Inspectors and describing the "do's and don'ts"; and
- (ii) a matrix in the form of a spreadsheet. This follows a standard, quite common methodology of rating (a) the severity or consequence of the hazard, and (b) the likelihood of the hazard actually causing harm. Both (a) and (b) are scored on a rating scale from 1 (very low) to 5 (very high).

First we will look at the text document, an example of which is given at [this link](#).¹⁸⁷

- The first statement of note is found in the first paragraph in the 'Policy' heading : "***we regulate in line with advice from the UK Government, Public Health England, Public Health Wales and Health Protection Scotland***". This reinforces the supposition that HSE have been instructed by Government how to regulate i.e. in line with PHE/IPC/BEIS¹⁸⁸ guidance as opposed to their normal regulatory regime based solely on health and safety legislation, without interference from any other party.
- Although the following paragraph states that compliance with health and safety legislation is still mandatory, it is impossible for dutyholders in healthcare to comply with the COSHH regulations since the notion that fluid resistant surgical masks are "PPE" or "RPE" flies in the face of [COSHH Regulation 7\(9\)\(b\)](#).
- The main risk control measures are set out on page 7. The risk control measures are solely concerned with avoiding contact with potentially contaminated surfaces, handwashing and social distancing. No consideration is given to inhalation risks whatsoever.

When we examine a later revision to the above document at [this link](#) we find something quite interesting.¹⁸⁹ This version of the document has been disclosed with Microsoft Word's "Track Changes" facility enabled so we can see the names of the people who were involved in editing and overseeing the document. We find evidence of Mr Philip White (Director of Regulation) editing the document himself. It is quite unusual in any organisation to see Directors personally getting involved in risk assessment. This may, of course, have been a genuine and laudable concern for the safety of his field staff. Alternatively some may interpret it as keeping a very close eye on things to ensure that it 100% reflected Government policy and constrained Inspectors from following their professional and self-preservation instincts to wear RPE when visiting hospitals or other sites where outbreaks had occurred.

An examination of the 5 x 5 risk matrix (at this link) is also quite revealing.¹⁹⁰

¹⁸⁷ Health and Safety Executive: Risk Assessment (Text) for Inspectors working externally (11 November 2020) ([Link](#))

¹⁸⁸ BEIS : The Department for Business, Energy & Industrial Strategy

¹⁸⁹ Health and Safety Executive: Risk Assessment (Text) for Inspectors working externally (26 January 2021) (showing 'track changes') ([Link](#))

¹⁹⁰ Health and Safety Executive: Risk Assessment (5 x 5 Matrix) for Inspectors working externally (26 January 2021) ([Link](#))

The first point to note is how they have classified the hazard of COVID-19 in their quantitative risk assessment i.e. the column labelled “CR” (Consequence rating). On the scale of 1 to 5 they have assigned a value of 3 (medium). This is curious, given the loss of life and serious illness which this pandemic disease was causing, particularly as the vaccine roll-out was not yet underway. They were most likely the only organisation in the country to assign a value of 3. Most businesses would assign a value of 4 (high) or 5 (very high) to a hazard which had a foreseeable outcome of death or very serious long-term disease. At that time, the potential seriousness of Long-Covid had been well-established and generally any disease with long-term debilitating disease (asbestos, silicosis, cancer) would be categorised as “high” or “very high”.

There is one other important point to note in the quantitative risk assessment. It identified the aerosol risk arising from exhaled breath as being less than 100 microns (the very issue described in section 6.1 above).

1.3 Infectious Disease - Coronavirus	Exposure to Covid-19 from smaller particles (<100um) exhaled by infectious persons that could become an aerosol in enclosed, internal spaces. In general most HSE Colleagues are transiting workplaces as an observer and will not be in enclosed spaces for long durations.	3	3	9
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Given that the HSE were instructed to regulate on the basis of the Government’s IPC guidance for healthcare settings instead of the law of the land, one would have hoped that they would have read that document thoroughly. If they had done so, they would have immediately recognised the fundamental flaw in the guidance that the IPC authors did not properly understand what an aerosol is. They believed that anything over 5 microns would harmlessly fall to the ground within 2 metres, which is absolutely not the case. HSE were seriously at fault for not correcting the IPC authors on this major scientific misconception which had such serious consequences, particularly in the healthcare sector.

11.3. HSE : A risk assessment too far?

It wasn’t until June 2021 that the IPC Cell introduced the concept of risk assessment, coupled with the ‘hierarchy of risk controls’, into their guidance in order to determine when RPE needed to be worn and when it did not. This was most likely at the prompting from HSE since, according to Dr Ritchie, in the early days of the pandemic they had never heard of the hierarchy of controls.

However, what was lacking was any guidance from the competent authority regarding the airborne risk and circumstances when RPE should be worn and when it was not necessary. So, at the HSE’s general meeting (26 July 2022) a representative of the RCN asked a very specific question on this exact point. The question and answer by Mr Richard Brunt (HSE Director) can be seen at [this video clip](#) [2m:27s].¹⁹¹

Given the unsatisfactory, vague and evasive response in which Mr Brunt side-stepped the question, another RCN colleague pressed the point further, seeking some sort of clarity from HSE. The question and answer by Mr Brunt can be seen at [this video clip](#) [1m:43s]. Mr Brunt concluded his brief and, once again, evasive answer by confirming his view that it was down to “*local risk assessment*”.¹⁹²

Following the General Meeting, CATA’s health and safety advisor wrote to Mr Brunt asking him, with all the expertise available to him at HSE, how he would undertake such a risk assessment, given that the following factors would make any attempt at a “suitable and sufficient” risk assessment impossible.¹⁹³ :

- Infectious aerosols in the air around the patient cannot be detected by any human sense (sight, smell etc)

¹⁹¹ HSE General Meeting (26 July 2022) : Question by Ms Estephanie Dunn regarding lack of HSE guidance for healthcare workers ([Link](#))

¹⁹² HSE General Meeting (26 July 2022) : Question by Ms Leona Cameron regarding lack of clarity from HSE as to when RPE is needed ([Link](#))

¹⁹³ Letter from to R. Brunt, Director of Policy & Engagement, HSE - Risk Assessment for close-quarter care of patients (11 Aug 2022) ([Link](#))

- The concentration of the infectious agent (SARS-CoV-2 virions) suspended in the air around the patient cannot be directly measured by any meter, monitor or other direct-reading instrument (unlike other airborne agents such as toxic gases, vapours, dusts and fibres).
- The effect of infection upon the worker cannot be reliably predicted. Even young, healthy, non-BAME, non-pregnant healthcare workers can (and have) become seriously ill with COVID-19, with many going on to either die or develop serious chronic complications (Long-Covid).

Mr Brunt did not reply to this letter (despite follow-up letters). A question along these lines was put to Mr Brunt by CATA's barrister, Mr Simblet KC, during his oral evidence session at the Covid-19 Public Inquiry.¹⁹⁴

"You knew it was airborne. Infectious persons expel virus-containing aerosols and the concentration of the virus is greatest, therefore, within 1 metre. My final question is this: Covid doesn't smell, it's invisible, it's silent, you can't detect it by any normal non-laboratory means, so would you agree, as a health and safety expert, that there's no realistic way that an individual healthcare worker could carry out their own individual risk assessment as to what equipment they would require when doing their job?", to which Mr Brunt replied ***"I'd agree entirely"***.

However he went on to add ***"it's not their responsibility to carry out a risk assessment, it's their employer's responsibility. We didn't expect individual healthcare workers to be carrying out individual assessments."*** which fails to answer the point Mr Simblet was making i.e. how could their employer (or, indeed, anyone working for their employer) carry out such a risk assessment. Unfortunately Mr Simblet had reached the end of his allotted questioning time and was not afforded any more time to press Mr Brunt on this point.

CATA would still appreciate a reply from Mr Brunt explaining how he, as an expert in health and safety, would do such a close-quarter risk assessment himself. Ideally the Inquiry will ask him that self-same question, and indeed CATA addresses the same question to the key individuals associated with the 4-Nations IPC guidance (M Wilcox, L Ritchie, E Davies, L Imrie, J Reilly).

11.4. Was HSE autonomous or was it under the control of UK Government?

We have already encountered statements from HSE officials strongly suggesting that frontline HSE Inspectors were under orders to enforce against standards which were not derived from health and safety legislation but to enforce against the 4-Nations IPC guidance i.e. 'toeing the Government line':

- _____;
- _____; and
- ***"We regulate in line with advice from the UK Government, Public Health England, Public Health Wales and Health Protection Scotland"***.

So the question is: "From where did the instruction to depart from its normal, statutory regulatory practice originate? Was it external pressures from Government or was it the internal decisions of HSE Senior Management, or both?"

We have discussed the evidence that DHSC influenced, or even directed, HSE to enforce RIDDOR in a particular way (or 'not enforce', as the case may be). Similarly we have discussed HSE Director, Mr Philip White setting out policy which suggested they regulate in line with PHE/IPC/BEIS guidance as opposed to their normal regulatory regime based solely on health and safety legislation. This infers that HSE was acting under instruction from Government.

On the other hand, we also have evidence from Ms Sarah Albon in which she denied that this was the case.

For a regulatory/enforcement body to set aside the statutory "law of the land" (COSHH, RIDDOR, PPE Regulations etc) and to regulate/enforce in a different way which had not been approved by Parliament is a matter which is highly relevant to investigations under Article 2 of the European Convention on Human Rights.

¹⁹⁴ UK Covid-19 Inquiry : Transcript of oral session : Witness Mr Richard Brunt, HSE PDF page 34, Transcript p.134 L21 ([Link](#))

CATA offered its observations on this matter in its closing written submission to the Inquiry ¹⁹⁵ :

“The COVID-19 Inquiry plays the central role of discharging the investigative duty under Article 2 of the European Convention on Human Rights”

“It is the Inquiry which has been able to marshal the evidence and resources to interrogate whether there has been a culpable state failure to put in place an adequate system, resources and equipment to preserve life in the event of a pandemic”

“These points are important, not because CATA invites any findings relating to breaches of Article 2 but because CATA submits that the Inquiry must analyse how such systems operated within their allocated resources and in practice. Failure properly to do this might leave a significant investigatory void”

CATA respectfully requests the Inquiry, whilst marshalling the evidence, to include the evidence we have presented in this report (especially in cases where State bodies have withheld evidence from it).

12. ‘Freedom of Information’ – Obstruction by Government Departments/Agencies

Much of the information contained within this document has been obtained by Freedom of Information (Fol) requests. Public Authorities have an absolute right to redact personal data such as names, email addresses, phone numbers and other personal identifiable data. However, when responding to our Fol requests, the authorities grossly overstepped the mark on numerous occasions, redacting data they are not legally entitled to redact.

They have also grossly exceeded the statutory requirements of the Freedom of Information Act 2000 to provide the information to the requestor within **20 working days**. Although some allowance has to be made for the fact that they may be very busy, have limited staff resources etc, the delays and impediments they have brought to bear on our research have been excessive and unacceptable. Their unwillingness to disclose the information can only be interpreted as “cover-up” of astronomical proportions. Some examples are as follows:

12.1. Department of Health and Social Care – Breach of Freedom of Information Act

A Fol request was submitted for disclosure of the 4-Nations IPC Guidance sent by Professor Sir Jonathan Van Tam to NHS-England and Public Health England on 12 March 2020. This was the version of the guidance which, through its implementation that night via the CAS-Alert system, denied most frontline healthcare workers the RPE/FFP3 that they needed for protection against the virus.

The reason for submitting this Fol was that, at the time the IPC Guidance was issued, COVID-19 was still classified as a High Consequence Infectious Disease (HCID) for which the health and safety requirements were for FFP3 respirators to be used. It seemed that this action had been not only a breach of health and safety rules relating to HClDs but also a breach of Health and Safety Regulations.

It took **27 months** to extricate the document from DHSC. During this time the Department first of all confirmed that it did have the document but refused to disclose it on the basis that it was “not in the public interest to do so”. It then denied that it had such a document and referred us to NHS-England. Only after a challenge, on the basis that they had committed an offence under section 77(1) of the Freedom of Information Act 2000, was the document forthcoming.

A further Fol for internal emails concerning the above Fol revealed that the document was held in the Chief Medical Officer’s office all the time, but there were multiple concerns about “sensitivities” associated with disclosure of the document. There were representations that it should not be released, but that if it had to be released then the CMO’s office wanted to have sight of the proposed response before it was sent. ¹⁹⁶

¹⁹⁵ Covid Airborne Transmission Alliance (CATA) Closing submissions to the UK COVID-19 Inquiry (20 December 2024) ([Link](#))

¹⁹⁶ Fol Details: **1)** Initial Fol request ([Link](#)); **2)** Open letter: Complaint - breach of s77(1) Freedom of Information Act 2000 ([Link](#))
3) DHSC internal email chain discussing possible Fol exemptions to avoid disclosing document ([Link](#))
4) Draft of ‘4 Nations IPC guidance ver 1.0’ disclosed 27 months after initial Fol request ([Link](#))

12.2. Public Health England / UK Health Security Agency – Breach of Freedom of Information Act

An FoI request was submitted to UKHSA seeking information relating to the fate of Dr Colin Brown’s “Formal Evidenced Proposal” for more widespread use of FFP3 to all frontline HCWs caring for infectious patients. This proposal was prepared on 23 December 2020 following his representations to the IPC Cell the previous day to this effect (discussed in detail at section 2.8).

It took **300 working days** to extricate the document from UKHSA. Even then it was only forthcoming thanks to the intervention of the Information Commissioner’s Office (ICO) issuing a ‘decision notice’¹⁹⁷ warning the Agency of ‘Contempt of Court’ proceedings if they failed to disclose the relevant information.

When UKHSA responded to the decision notice they stated that the ‘Formal Evidenced Proposal’ had been taken over by a ‘senior UKHSA official’ and amended after the author (Dr Brown) had gone on Christmas leave.

A further FoI request was submitted for the amended version since it was known that the proposal to broaden the use of respirators was quashed. CATA sought to find out the reasons/justification given by the senior official for overriding the expert advice from their IPC specialists and to establish whether there had been influence or pressure from other parties.

At the time of submitting this report they have remained silent on the matter for **100 working days**. As a result of this delay, the Information Commissioner has deemed it necessary to serve yet another ‘decision notice’ requiring them to disclose this by 12 March 2026 or face contempt proceedings.¹⁹⁸ CATA has decided that it cannot wait for this evidence to arrive before finalising and submitting this report.

It is suspected that UKHSA’s reluctance to disclose this information is because it will reflect poorly on certain individuals who held senior management positions in PHE back in December 2020, who may fear reputational damage and/or potential accountability for:

- (a) blocking Dr Brown’s initiative to extend the use of FFP3 respirators; and
- (b) subsequent deaths/ill-health of HCWs left unprotected at the Covid front line.

Such individuals may include the then COVID-19 Incident Director (now Chief Executive), Professor Susan Hopkins.

The Inquiry is invited to investigate this matter further. It was a pivotal moment during the pandemic when the opportunity to prevent chronic ill-health conditions and save HCW lives was rejected. It should also be of concern that UKHSA failed to disclose this ‘amended Formal Evidenced Proposal’ to the Inquiry when it was quite obviously a relevant document which would be of interest to the Inquiry and to the questions put to Dr Barry Jones on 12 September 2024 by Mr Scott KC.

12.3. NHS England – Breach of Freedom of Information Act

- A response from NHS-England to an FoI request for sight of a set of IPC Cell minutes (13/1/2020) is probably the most graphic, literal example of “cover up”:



Fig 2: NHS England response to an FoI for a set of IPC Minutes (13 Jan 2021)

¹⁹⁷ Decision Notice #1: Information Commissioner to UKHSA : Disclose information relating to ‘Formal Evidenced Proposal’ (14 Aug 2025) ([Link](#))

¹⁹⁸ Decision Notice #2: Information Commissioner to UKHSA : Disclose information re ‘Amended Formal Evidenced Proposal’ (11 Feb 2026) ([Link](#))

A complaint was lodged with the Information Commissioners' Office since public authorities are only permitted to redact personal information and not information that they simply do not want the data-requestor to see. The ICO instructed NHS-E to disclose the minutes appropriately redacted, which was then received.¹⁹⁹

12.4. Health and Safety Executive – Breach of Freedom of Information Act

When CATA received the information pertaining to Ms Miranda Morton's briefing note to Ms Sue Tranka (section [8.1](#)) there was interest in discovering the information which had been given at the meeting she had attended the previous day. This had been hosted by HSE's Chief Scientific Advisor (Prof Andrew Curran) and other expert scientists involved in the Health and Safety Executive's 'PROTECT' National Core Study.

An FoI was submitted to HSE for this information on 16 July 2025. After 80 working days and no response from HSE the Information Commissioners' Office instructed them to provide the information within 10 working days. The HSE did respond but did not provide the information requested.

The information requested was for the notes or minutes of the HSE Chief Scientific Advisor's 'transmission update' meeting that was held on 22 March 2022, including any handouts or copies of presentations made at that meeting which were sent to attendees following the meeting.

However, HSE only provided a selected few slides from one presentation in their response to the FoI. These all related to outgoing transmission (i.e. the impact of voice volume on aerosol/droplet dissemination and environmental survival time of the virus). They did not include any information relating to the factors which Ms Morton had referred to in her briefing note i.e. relative filtering capabilities of surgical masks, FFP2/3 respirators etc.

An appeal (otherwise known as an 'internal review') was submitted to HSE on 29 November. ICO consider 40 working days to be a reasonable timescale for public authorities to conduct internal reviews. As no response was provided within this timescale a complaint was lodged with the ICO (31 January).

The ICO have advised our researcher that they have accepted the case for investigation. However, due to a backlog of cases and resource issues it seems that the case may not be allocated to a case officer until September 2026. Meanwhile the HSE, a regulatory body which prosecutes organisations and individuals who commit offences under the health and safety legislation which it enforces, itself commits offences under the Freedom of Information Act.

It is hoped that the details outlined above adequately illustrate the difficulties that CATA has experienced in trying to obtain information which the public have an absolute legal right to access in a timely manner. Although a great deal of useful information has been obtained by the FoI process, one can only imagine how many other documents remain undiscovered, either by the Inquiry or by CATA. Although CATA will pursue the outstanding FoI requests, it will not issue any further FoI requests. Only the UK Covid-19 Inquiry has the power and authority to force disclosure of any further relevant documents which are being concealed by Government Departments.

¹⁹⁹ IPC Cell minutes (13 January 2021) ([Link](#))

13. Legal considerations

It is not within CATA's remit to make any recommendations regarding litigation. The following observations are offered for the Inquiry Chair's consideration as it is she who will make recommendations if, indeed, any need to be made.

13.1. Health and Safety Legislation

The Health and Safety Executive, at their own admission, enforced against the requirements of Government guidance instead of the requirements of health and safety legislation. In healthcare, they enforced against the requirements of the 4-Nations IPC Guidance, although many would argue that any such 'enforcement' was minimal.

The COSHH and PPE Regulations were, to all intents and purposes, suspended. IPC guidance was given supremacy over the law of the land. There was no legal/statutory basis for this whatsoever. These regulations were not revoked, suspended or modified by the emergency powers introduced by Government early in the pandemic.

NHS Trusts and Health Boards failed to comply with the COSHH/PPE Regulations as a direct result of the mandatory nature of the IPC guidance. The preface in all iterations of the IPC guidance that Trusts must also comply with health and safety legislation was meaningless, in that the IPC guidance mandated a breach of that legislation by making it compulsory to wear FRSM whilst providing direct care to infectious patients, contrary to the requirements of COSHH, where RPE is required when exposed to highly pathogenic microorganisms, particularly when close to the source and where other mitigations are not possible or ineffective.

Lest there be any debate or uncertainty about this important point, instructions such as the one below imperilled healthcare workers by forcing them to wear a device which does not protect them against infection by inhalation:

COVID-19: Guidance for infection prevention and control in healthcare settings. Version 1.1, 27/03/20

- A FRSM must be worn when working in close contact (within 1 metre) of a patient with COVID-19 symptoms. This provides a physical barrier to minimise contamination of the mucosa of the mouth and nose.

It was therefore impossible to comply with both health and safety legislation and also comply with the IPC guidance, since the two required mutually contradictory courses of action.

The IPC guidance was robustly enforced by most healthcare employers, to the extent of confiscating self-purchased RPE and threats of disciplinary action if RPE was worn in place of FRSM. Threats were even made that a HCW family would be denied the £60K 'death in service' payment if that HCW continued to wear the RPE but died of COVID-19.

The only inference which can be drawn from this is that the IPC guidance caused employers to commit health and safety offences (namely section 2 of the Health and Safety at Work etc Act 1974 (HASAWA) and Regulation 7 of the Control of Substances Hazardous to Health Regulations 2002).

Section 36(1) of the HASAWA relates to "Offences due to the fault of another person". It states:

"Where the commission by any person of an offence under any of the relevant statutory provisions is due to the act or default of some other person that other person shall be guilty of the offence. and a person may be charged with and convicted of the offence by virtue of this subsection whether or not proceedings are taken against the first-mentioned person."

It is important to note that the term 'person' includes bodies corporate (Interpretation Act 1978, s.6(1)) which, for the sake of example, would include the UK Health Security Agency and NHS National Services Scotland (having regard to the acts and omissions of ARHAI) .

Consider a practical example from, say, an industrial workplace:

- an employer has some work to be done where, for instance, harmful gases such as sulphur dioxide, ammonia or carbon monoxide are likely to be present;
- the employer seeks advice from a health and safety consultant who advises that employees should wear some basic face-covering such as an ordinary FFP1 respirator mask (or even a surgical mask) for protection;
- Some employees who carry out the work die as a result, while others sustain severe injury to their lungs, leading to life-long health issues

The consultant who gave this advice has committed a section 36 offence and is liable for prosecution, leading to a fine and/or imprisonment – even if the client (the employer) is not prosecuted for any offence.

It does not take a great leap of imagination to extrapolate the above scenario to the situation where hundreds of healthcare workers were killed by COVID-19 and thousands suffered injury to health.

Even though the Inquiry Chair cannot determine matters relating to criminal liability, section 2(2) of the Inquiries Act 2005 expressly makes it clear that this should not inhibit her from determining the facts or from making recommendations. There will be hundreds of injured healthcare workers hoping that she will do so.

Although a conviction under section 36 does not automatically give rise to civil liability, the fact of a successful prosecution may carry persuasive weight before a judge considering a personal injury or negligence claim, as in the ongoing class action by injured healthcare workers currently before Senior Master Cook.

13.2. The Inquiries Act 2005, Section 35(3)(a)

Section 35(3)(a) : “***A person is guilty of an offence if, during the course of an inquiry he intentionally suppresses or conceals a document that is, and that he knows or believes to be, a relevant document***”.

CATA has presented evidence of numerous documents being held by state bodies which do not appear to have been disclosed to the Inquiry, but which have been prised (albeit rather reluctantly) from those organisations via Freedom of Information requests. CATA acknowledges that those documents may have been provided to the Inquiry in connection with modules other than module 3, to which CATA is not allowed access. However the nature of the documents is undeniably relevant to module 3 and it seems likely that they would have fallen within the scope of the Inquiry’s rule 9 requests to those organisations for witness statements.

To take one instance by way of example. Ms Sue Tranka (CNO, Wales) adduced document INQ000227346 into evidence along with her witness statement (INQ000274148_0017). This related to the four Chief Nursing Officers’ concerns as to the adequacy/inadequacy of the 4-Nations IPC Cell guidance early in December 2021.

One might therefore ask why the series of emails between Ms Sue Tranka, Dame Ruth May, Professor Mark Wilcox and Dr Eleri Davies were not disclosed to the Inquiry. Neither was the briefing note from Ms Miranda Morton which, once again, raised absolutely identical concerns about the adequacy/inadequacy of the 4-Nations IPC Cell guidance just 3 months later on 23 March 2022 (see section [8.1](#) above). That correspondence was highly relevant to module 3 and, in CATA’s submission, should have been made available to the Inquiry and to all core participants. It should be borne in mind that these email chains and Ms Morton’s briefing note would have been held by NHS Wales, NHS England, NHS Scotland, NHS Northern Ireland, the Chief Medical Officer (Wales) and Public Health Wales, yet none of these organisations appear to have disclosed these documents to the Inquiry.

In all, approximately 100 emails have been obtained by Freedom of Information requests which cannot be found in the Inquiry’s ‘Relativity’ System for module 3 – including some highly relevant ones from UKHSA and DHSC. One can only speculate how many more documents may have been concealed from the Inquiry and from core participants. Any such documents will be relevant to the class action which is before Senior Master Cook. The Inquiry is ideally placed to use its powers to ensure that any concealed evidence is produced.

13.3. Article 2, European Convention on Human Rights (ECHR), Right to Life

CATA offered its observations on this matter in its closing written submission to the Inquiry ²⁰⁰:

“The COVID-19 Inquiry plays the central role of discharging the investigative duty under Article 2 of the European Convention on Human Rights”

“It is the Inquiry which has been able to marshal the evidence and resources to interrogate whether there has been a culpable state failure to put in place an adequate system, resources and equipment to preserve life in the event of a pandemic”

“These points are important, not because CATA invites any findings relating to breaches of Article 2 but because CATA submits that the Inquiry must analyse how such systems operated within their allocated resources and in practice. Failure properly to do this might leave a significant investigatory void”

CATA respectfully requests the Inquiry, whilst marshalling the evidence, to include the evidence we have presented in this report. This is especially the case where State bodies have withheld evidence from the Inquiry. The Inquiry should ensure that State bodies review the document disclosures they have made thus far, identify where relevant documents have been withheld and provide them to the Inquiry. Ideally this process will be independently audited. It is essential that such evidence is available:

- (a) to inform any determination under Article 2 ECHR; and
- (b) to assist the Covid Deaths Investigation Team (CDIT) of the Scottish Crown Office and Procurator Fiscal Service with its investigations into the death of Mr Neil Alexander and other healthcare workers who died of COVID-19 under circumstances which suggest occupational exposure to be the cause.

In the case of the late Mr Alexander, it is especially important that all relevant documentation is extracted from state bodies in relation to the rejection of Dr Colin Brown’s proposal on 22 December 2020 to apply the precautionary principle and extend the use of RPE. Documentation should be sought, especially from UKHSA, NHS England, NHS Scotland, ARHAI, CNRG and the IPC Cell.

This is particularly relevant because Mr Alexander contracted COVID-19 on or shortly after 13 Jan 2021, having been deployed to work on a ward in Woodland View Hospital, NHS Ayrshire and Arran, where a known COVID-19 outbreak was in progress. He tested positive 8 days later and died on 14 February 2021. The ramifications of the decision three weeks earlier by the IPC Cell to suppress wider use of RPE across the four nations, together with the influence of ARHAI personnel will be a relevant factor in the CDIT enquiries. CDIT officers are investigating to establish whether any criminal offences have been committed in relation to Mr Alexander’s death and that of other Scottish healthcare workers who died of COVID-19.

13.4. Misconduct in public office

CATA has presented some evidence in this report which may warrant investigation as to whether any offences have been committed in respect of misconduct in public office. As above, the Chair should not be inhibited from making any such recommendations.

²⁰⁰ Covid Airborne Transmission Alliance (CATA) Closing submissions to the UK COVID-19 Inquiry (20 December 2024) ([Link](#))

14. Closing reflections

As mentioned in the foreword, this report has been prepared by CATA in order to summarise the investigations which it has carried out independently since its formation in 2022 and previously, whilst known as the AGP Alliance and then the Covid Airborne Protection Alliance.

CATA's purpose is to assist the UK COVID-19 Inquiry with its own investigations into events which occurred during the 'relevant period' of the COVID-19 pandemic (1 Mar 2020 – 28 June 2022). Evidence has been collected and summarised in this report, together with a narrative of events, insofar as limitations such as redactions in FoI documents permit.

It is essential that CATA's intentions in providing this information are clearly understood i.e. to identify any acts and omissions by state bodies which may be of relevance to the UK COVID-19 Inquiry, other parties involved in litigation and, of course, anyone (healthcare worker or otherwise) who may have been affected by COVID-19 under circumstances which may have been prevented if airborne transmission and the need for respiratory protection had been properly recognised from the outset of the pandemic.

This inevitably involves identification of individuals and groups of individuals which were involved in the matters under investigation. This report is not making any accusations or allegations against any individuals or organisations. It's purpose is simply to provide documentary evidence, together with its context – no more than that. It is for the Inquiry and other authorities to determine whether the acts or omissions of these individuals represent culpable or discreditable conduct.

CATA Executive Team:

Dr Barry Jones BSc MBBS MD FRCP, Chair

Ms Kamini Gadhok MBE, BSc (Hons), Doctor of Civil Law (Honorary), MSc (Honorary), MRCSLT, Vice Chair

Professor Kevin Bampton, Chief Executive Officer, British Occupational Hygiene Society

Mr David Osborn, BSc SpDipEM, Health and Safety Consultant

Appendix 1 : Emails within DHSC relating to FFP3 stock levels

The following is a timeline of email correspondence obtained by Freedom of Information requests (hence most names redacted by DHSC).

Key: Sec of State = Senior Private Secretary to the Secretary of State Rt Hon Matt Hancock MP

Marron = Jonathan Marron, Director General for Public Health

MDO = Michael Dynan-Oakley, Deputy Director, PPE Policy, Briefing and Engagement

SpAds = Special Advisors to Secretary of State

(Highlights and font colouring mirror the original email DHSC chains.)

Date/Time	From	To	Text
21 Dec 20 20:22	Sec of State	Marron, MDO, SpAds	The SoS has requested some urgent advice on supplies of FFP3 masks. In particular how many we currently have available, and how supply levels are in relation to our current demand. Please could we have this by 11am tomorrow? Grateful for an answer on the current number of masks tonight if we have it to hand.
21 Dec 20 20:56	Head of PPE Briefing	SoS	As of last Friday - we have 43m units of FFP3s against a target stock level of 35m. Can confirm most current numbers in the AM.
22 Dec 20 09:34	(Redacted)	(Redacted) cc : Marron	■ and ■ have been looking at this and modelling what happens if FFP3s become standard.
22 Dec 20 10:06	(Redacted)	(Redacted) cc : Marron	■ has this covered but let's also take the opportunity to promote UK manufacturing on this one - it is ultimately the reason why we will be in such a good position to react to any change.
22 Dec 20 10:33	(Redacted)	(Redacted) cc : Marron	V happy to take contributions to round this out. Starter for 10 below to make it easier ■ - welcome input and corrections. • We currently have 43m units of FFP3s against a target stock level of 35m (where target stock level is 120 days of supply). • We have even more incoming stock of FFP3s, amounting to a total procured of X. • We have already begun modelling to understand requirement for FFP3s if they were to become the standard, and are confident that we have the supply secured to meet that demand [??]. • Furthermore additional resilience is provided by UK make capacity for FFP3s, which can produce [?]
22 Dec 20 12:26	(Redacted)	(Redacted) cc : Marron	Thanks ■ - UK manufacturing can produce 13M/month. (■ this is the last update we provided through the OC deck). ■ is working through what this number is in relation to actual demand. If higher than actual demand then we can be stronger on point for and say that our UK manufacturing capacity will meet ongoing demand
22 Dec 20 12:28	(Redacted)	(Redacted) cc : Marron	Thanks ■ and I spoke earlier. We agreed better for SoS to get the full picture through a proper submission from Tom and team v soon, rather than this ad hoc briefing. I'll speak to his Private Office that more will come, but not in response to this request necessarily.
22 Dec 20 12:33	(Redacted)	(Redacted) cc : Marron	OK ■ but I think the scale of UK capacity should add confidence even if we have to do extra work to validate this.

Date/Time	From	To	Text
22 Dec 20 14:38	(Redacted)	(Redacted) cc : MDO	Circling back after earlier discussions. Removing JM so we can finalise and then get him to clear. SoS office keen to get something this arvo if poss. • We currently have 43m units of FFP3s in the country against a target stock level of 35m (where target stock level is 120 days of supply). • We have a further stock of FFP3s incoming, amounting to a total procured of X. • We have already begun modelling to understand how requirement would change for FFP3s if IPC guidance shifted to recommending more widespread use, or if we find there is a greater demand signal for FFP3s from trusts. [What's the current brief to give on this – presumably not the worst case scenario number from earlier!] Furthermore, additional resilience is provided by UK make capacity for FFP3s, which can produce an additional 13m units per month. [Do we need to add anything about the logistical aspect or is that opening a can of worms with SoS right now]
22 Dec 20 15:03	MDO	(Redacted H)	We could do a note on the guidance, although we are unlikely to have much detail. Meanwhile – (Redacted H) please could you contact [Colin] and [Lisa] to work out what we would say.
22 Dec 20 15:09	(Redacted H)	MDO	Happy to get in touch with [Colin] and [Lisa]. Can I double check we want policy lines from them in terms of how the guidance is likely to change/ what our recommendations within the IPCG are likely to be regarding the use of FFP3s?
22 Dec 20 15:28	MDO	(Redacted H)	I think we need them to confirm/flesh-out (perhaps), the understanding they gave us at lunch time of what is coming down the track on the IPC guidance: • Guidance not changing at this time in respect of the PPE needed in different settings; • New focus on associated comms around pathways, Red in particular, where sessional use of FFP3s is already in the guidance for workers exposed to known COVID-19 cases and AGPs, which may accelerate the draw on FFP3s a little as this existing guidance may not be closely observed across acute trusts; although on the flipside, some trusts will already be upping their approach to FFP3s for sessional use in Red Pathways; • FFP2s as an alternative to an FFP3 remains a feature of the guidance; • Aiming to publish in the next two days; • There will be a comms push on the safe use of PPE, donning, doffing, clean hands etc; Maybe tweak this and seek urgent comments!?
243 Dec 20 09:33	(Redacted H)	MDO, Marron	Please see the lines on FFP3s agreed by the IPC Cell • IPC Guidance will not be changing at this point in time in respect of PPE needed in different settings; however the guidance will be kept under review as we know more about the variant. • There are ongoing discussions around increasing the use of FFP3s in clinical areas where AGPs are not regularly being undertaken in the high risk pathway. If there is consensus from the UK IPC Cell for this approach, this will be included within the revised guidance due to be published within the next couple of days. This may accelerate the use of FFP3s, however, we expect some trusts will already be enhancing their approach to FFP3s for sessional use in Red pathways. (N.B. The UK IPC Cell have been asked to comment on this by midday today) • Aiming to publish the revised IPC guidance within the next two days. • There will be a comms push on the safe use of PPE, donning, doffing, clean hands etc.

Date/Time	From	To	Text
23 Dec 20 09:38	Marron	(Redacted H) MDO	I'm not sure I understand. First bullet says no change. The second says still considering a change. I think we need to be clear. If we are only thinking about a change for high risk settings we should be clear about what these are. Also helpful to be very clear on the process for agreeing the IPC guidance and who signs off.
23 Dec 20 09:42	(Redacted)	Marron, MDO (Redacted H)	Thanks Jonathan and [REDACTED] I'll pick up this points again with [REDACTED] if MDO and team can go back to their contacts for a little extra clarification as well.
23 Dec 20 09:45	(Redacted H)	Marron, MDO	I have asked the IPC Cell for clarification.
23 Dec 20 11:01	(Redacted H)	Marron, MDO	As the UK IPC Cell is due to finalise the position on changing the guidance for the Red Pathway by noon today, I will circulate lines after this position has been agreed so that the lines are clear i.e. there will be no change to the guidance or the only change will be within the Red Pathway.
24 Dec 20 14:44	(Redacted H)	Marron, MDO	Apologies for not sending lines on the IPCG yesterday, it's taken the UK IPC Cell a little longer than anticipated to come to a consensus. The current position is as follows: • There is currently insufficient evidence to change the IPC Guidance / PPE precautions in response to the emergence of the new strain, therefore the IPC Guidance will not be changing at this point in time in respect of PPE needed in different settings. • The UK IPC Cell and PHE have agreed to continue to monitor and review the emerging evidence and data and if this situation changes end the guidance accordingly. • Amendments to the IPCG have been made to strengthen existing messaging and provide further clarity where needed, including updates to the care pathways to recognise testing and exposure. There will be a comms push on the safe use of PPE, donning, doffing, clean hands etc. • Separately, to note, the IPCG will also recommend that valved respirators should not be worn by a healthcare worker/operator in a sterile area such as theatres/surgical settings and non-valved respirators should be used instead. The IPC Cell have confirmed that this is not COVID related, rather a general patient safety issue. [REDACTED] has confirmed that from a supply perspective, this amendment will not cause any issues for us as we have lots of stock. Hope that helps and let me know if you have any further questions.